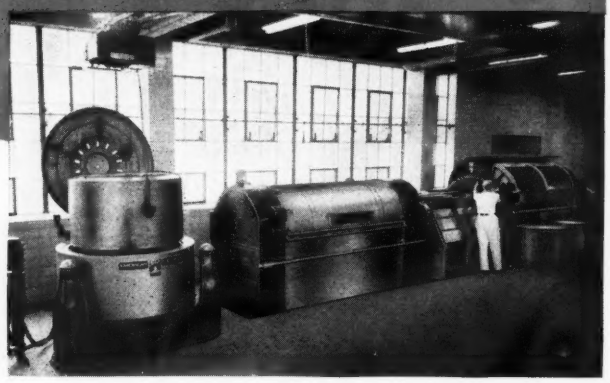
THE CANADIAN HOSPITAL

OFFICIAL JOURNAL
CANADIAN HOSPITAL COUNCIL

SEPTEMBER, 1948

Canadian

Modernized the Laundry Department at 300-Bed Hackensack Hospital, Hackensack, N. J.



In modernized, labor-saving laundry at Hackensack Hospital, operator mechanically unloads one of two CASCADE Automatic Unloading Washers with Companion Washing Controls into NOTRUX Extractor Containers.

PROBLEM

Old, out-moded equipment in laundry at Hackensack Hospital proved inadequate to meet greatly increased demands for clean linens.

SOLUTION

Our Laundry Advisor was called in to help plan a modern laundry to be installed in new building. He carefully surveyed laundry requirements and submitted his recommendations for most efficient, cost-saving production. Hospital then installed latest, high-speed equipment, partially shown here.

Saving two operators, this 8-Roll SYLON Flatwork Ironer with TRUMATIC Folder beautifully irons and automatically folds large pieces at high speed.

RESULTS

Hackensack Hospital reports plenty of clean linens are always available to satisfy demands. Quality of laundering is better, costs are lower. Old laundry required 17 operators working 60 hours a week; modernized laundry has only 12 operators, working 40 hours per week.

CALL IN our Laundry Advisor to help solve your laundry problem. WRITE TODAY. There's no obligation.

Remember . . .

Every Department of the Hospital Depends on the Laundry.

The CANADIAN LAUNDRY MACHINERY CO. LIMITED

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WESTERN REPRESENTATIVES—Stanley Brock Limited, Winnipeg, Calgary, Vancouver.

Bovine blood can be collected and handled under carefully controlled, sanitary conditions. Protein Hydrolysate, Baxter, is prepared from the plasma of this blood because plasma proteins properly processed are good proteins*. Enzymatically digested, the proteins are converted into amino acids and peptides with a minimum change in structure. A new booklet, Protein Hydrolysate, Baxter, is yours for the asking. Baxter Laboratories of Canada Ltd., Acton, Ontario.

Journal of the American Dietetic Assn. Vol. 23 #10 Page 841 October 1947.

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With or without Dextrose

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Lustre-Clean makes all dirt and grime disappear to be replaced by a fresh, glossy wax finish which brings up the natural beauty of your floors. Hard-to-remove footprints vanish like magic. If you'd like further information on this safe, effective, money-saving floor cleaner, contact one of West's large nationwide staff of trained sanitation specialists at once.

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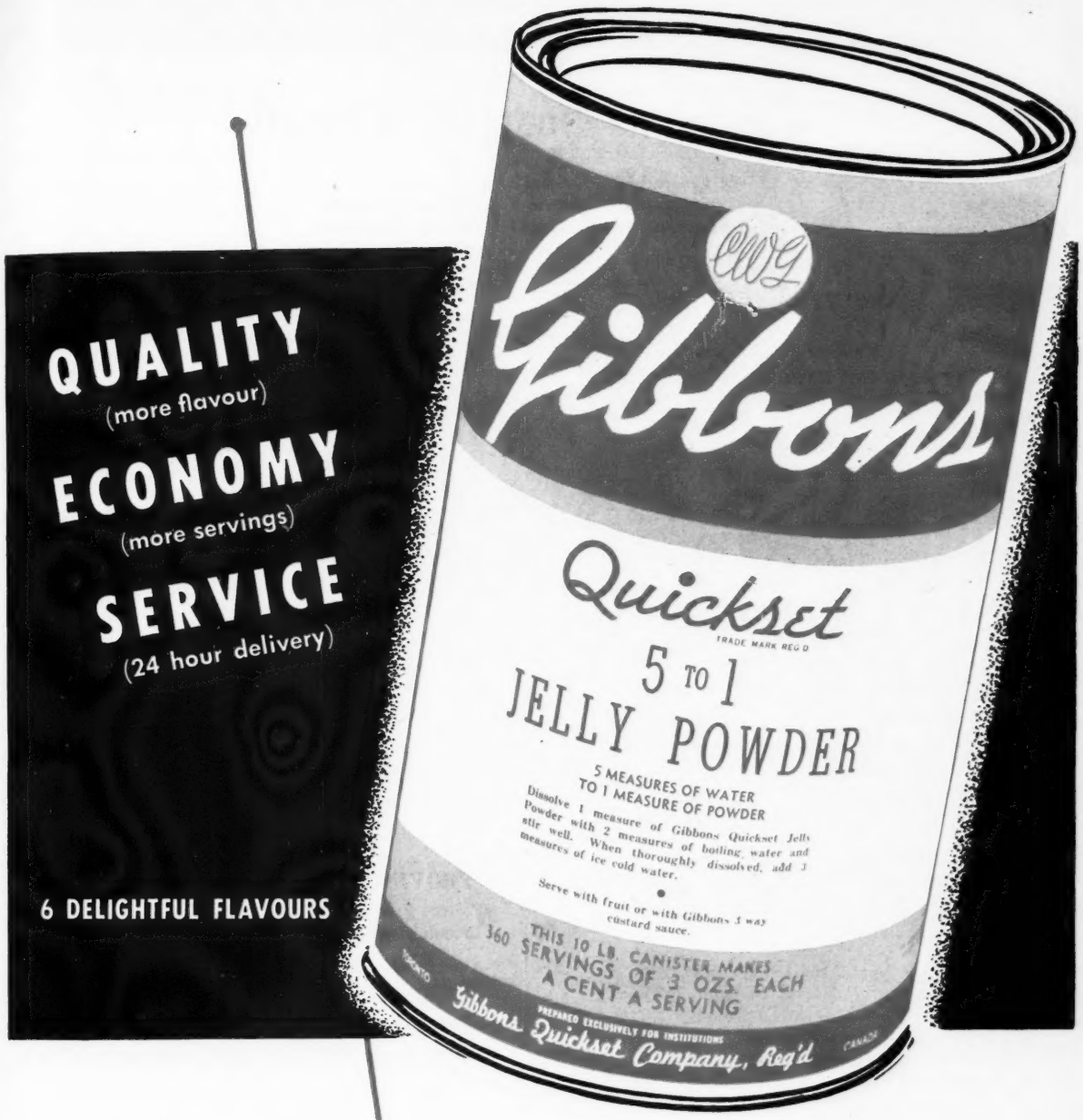

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New...Improvements in PRECISE SURGICAL LIGHTING ... *PRODUCED BY HOLOPHANE RESEARCH*

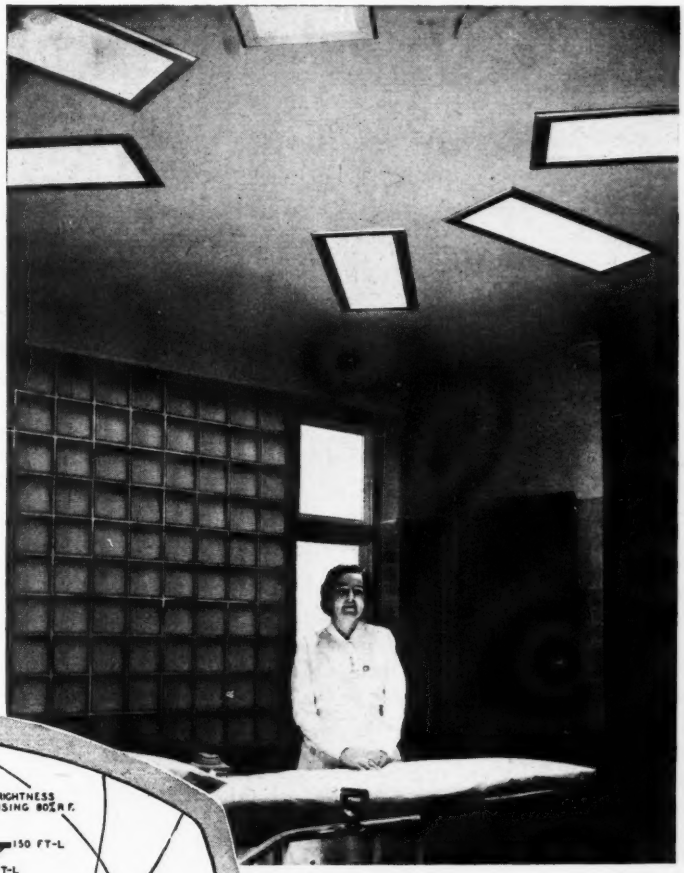
In the field of surgery, precision lighting is of crucial importance. Holophane engineering has provided outstanding improvements in this specialized illumination. Consider the features that distinguish new Holophane surgical lighting systems from all others:

EFFICIENT . . . Scientific grouping of enclosed multi-lens optics assures maintenance of intense illumination—without sacrifice of correct brightness throughout the entire field of view.

SAFE . . . Location of lighting systems remote from anaesthetization zone eliminates hazards of explosion; multiple lamping avoids danger of interruption from lamp burnouts.

ASEPTIC . . . Permanently flushed into tight ceiling enclosures. No moving parts to dislodge dust.

MODERN . . . Direction and pattern of light are pre-set—can be changed, without distracting surgeon, by remote wall switches.



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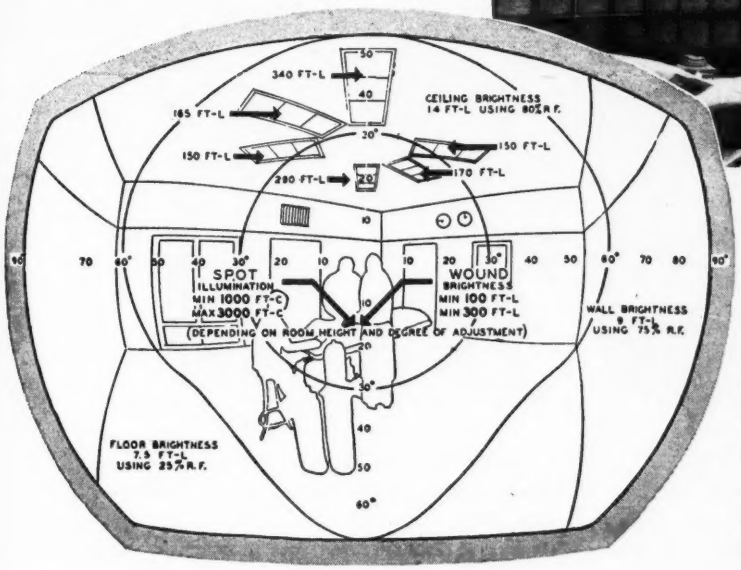

ILLUMINEERING PERSPECTIVE OF A SURGERY LIGHTED BY 6 HOLOPHANE F-1715-3

Write for engineering data on Holophane's "New Surgical Lighting Systems" including speci alinstallations.

VISUAL COMFORT — Diagram at left shows that brightness contrasts throughout the operating room are extremely low. The lenses that could conceivably cross the surgeon's glance are only 1½ times brighter than the minimum wound brightness; are less bright than the maximum wound brightness.

THERMAL COMFORT—No matter what the surgeon's position, lights that his body blocks can be switched off to reduce temperature rise on surgeon's back—important in lengthy operations. In addition, the use of heat-absorbing lenses accomplishes two purposes: reduces the direct infra-red transmission (heat waves) and corrects the light color toward true white.

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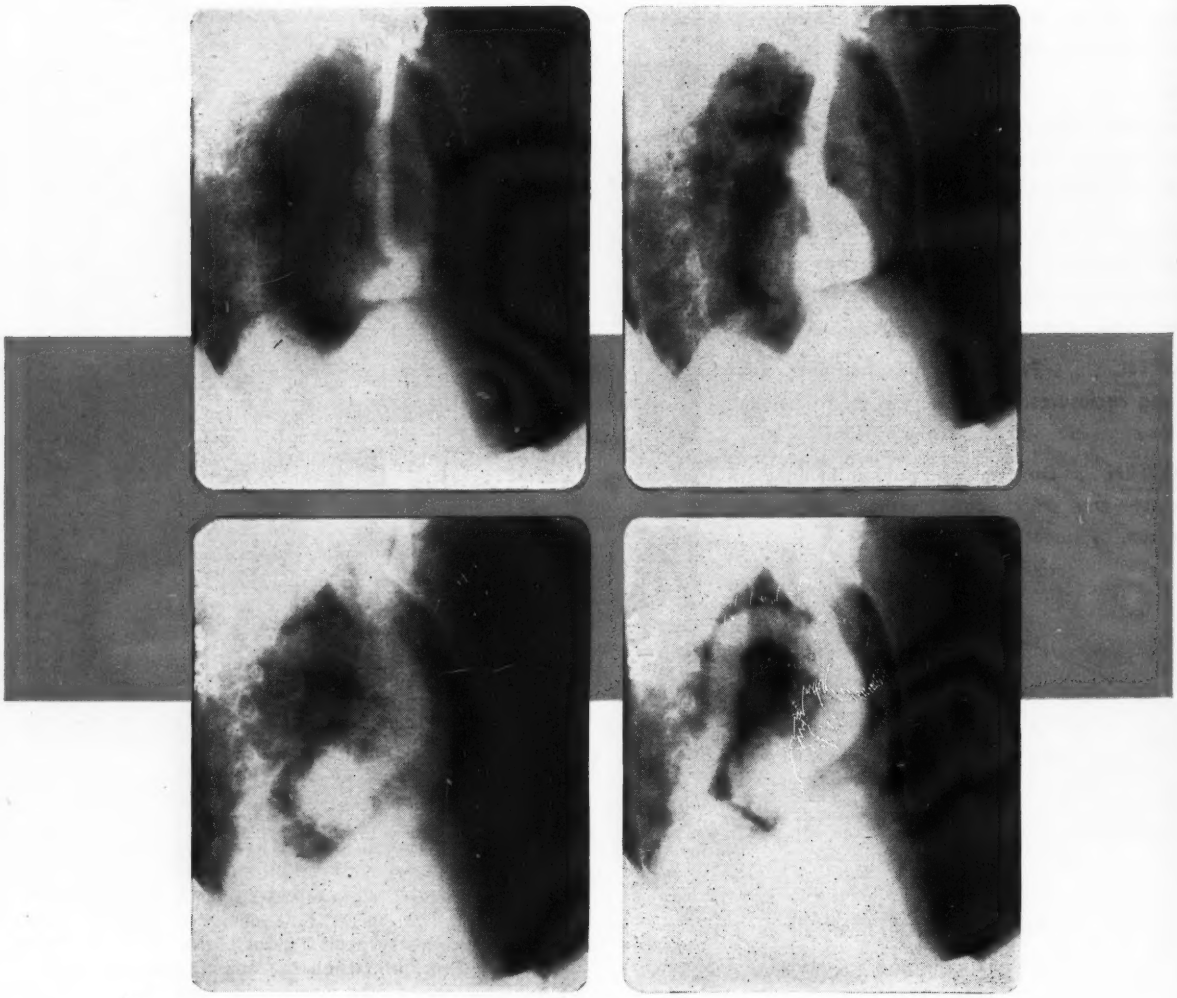
eyes that watch the heart in action

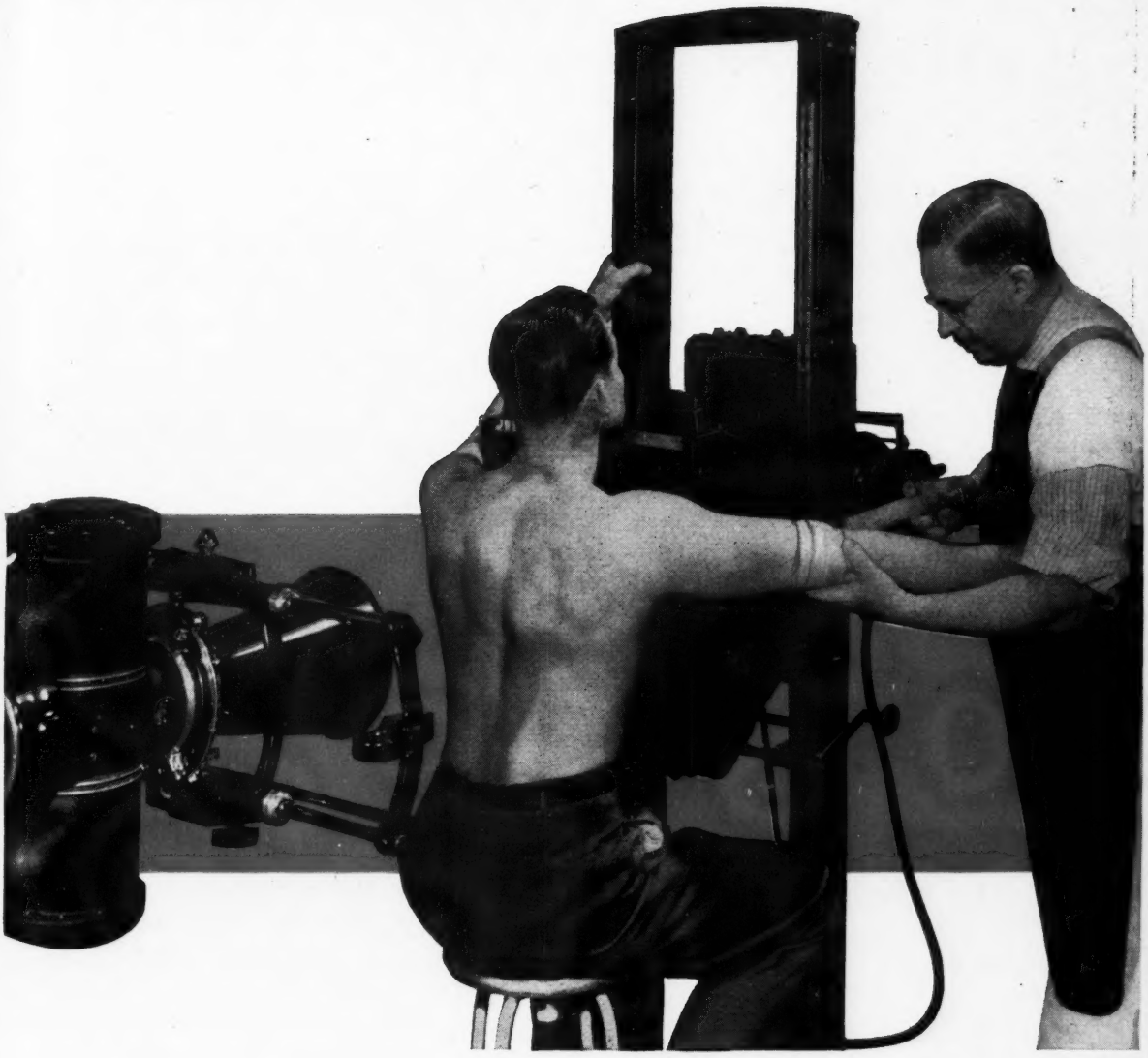


A complete circulatory cycle takes approximately 15 seconds. Now . . . the physician may follow the cardiac phase of this cycle . . . assemble on film a complete record of the heart at work.

This new technic of angiocardiography calls for an automatic, rapid-change photo-roentgen unit that can be speeded up to take 10 or more exposures on 70-mm film within a 15-second period. The G-E Photo-roentgen unit is immediately adaptable.

Using this new technic, with a modified General Electric Photo-roentgen unit, one injection of the contrast medium will demonstrate the movement of the opaque through the right and left cardiac chambers and associated great blood vessels.

Your ally in the unending struggle for man's improved physical welfare, General Electric X-Ray design assures you that the finest x-ray equipment you can own bears the G-E emblem.



THE G-E PHOTO-ROENTGEN UNIT DOUBLES IN ANGIOCARDIOGRAPHY

New General Electric Photo-roentgen units are now available already modified for angiocardiography. The advantages of the new technic are also available to owners of existing G-E Photo-roentgen units. All necessary modifications can be made on any G-E Photo-roentgen unit.

The modifications do not interfere with the primary use of this G-E apparatus for chest survey work. The hospital owning a modified G-E Photo-roentgen unit can not only take routine chest films of entering patients, but can also provide the cardiologist with a means of obtaining a more exact cardiac diagnosis.

Modifications are simple. For further details on the application of the General Electric Photo-roentgen unit to angiocardiography, write General Electric X-Ray Corporation, Dept. I-29, 4855 McGeoch Ave., Milwaukee 14, Wisc.

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ACOUSTI-CELOTEX is the acoustical material that is paintable and takes decoration without losing its sound conditioning properties. Illustrated—ceiling of operating room, Fort William Sanitarium.

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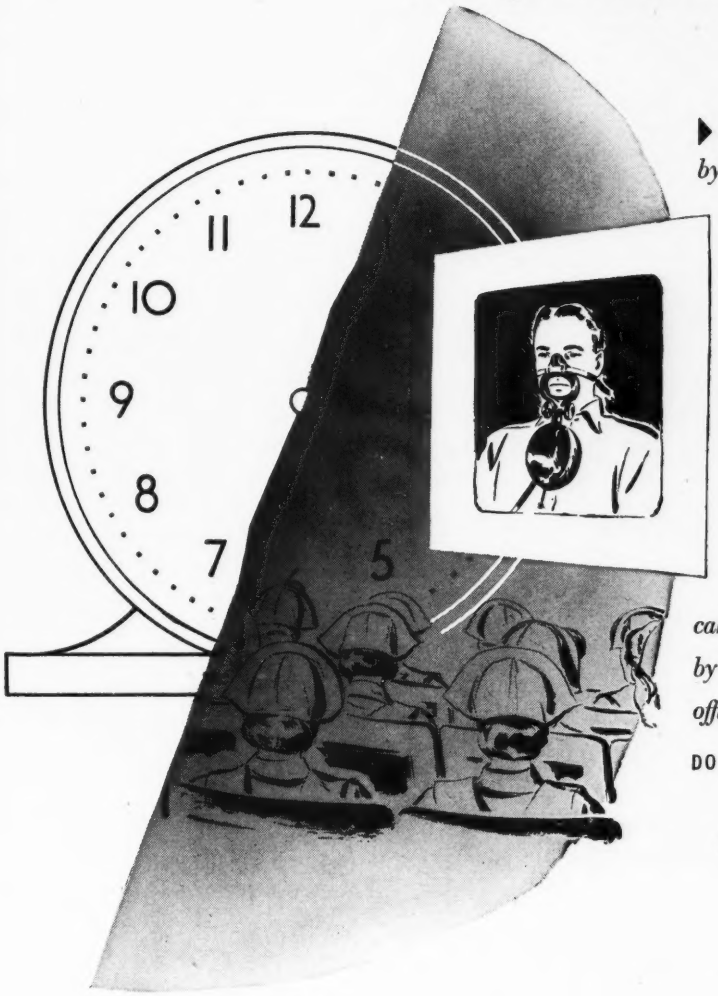
How much time

can you save in a half hour?



Nurses can save hours of study by spending 30 minutes seeing the film, "Oxygen Therapy Procedures." It illustrates and explains accepted oxygen therapy techniques.

This motion picture is approved by the Committee on Medical Motion Pictures of the American College of Surgeons, and is one of our services to users of DOMINION oxygen (B.P.). You can arrange a showing of this film by calling or writing the nearest DOC office. Ask for film T.O. 1.

DOMINION OXYGEN COMPANY, LIMITED

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159 Bay Street, Toronto 1, Ontario

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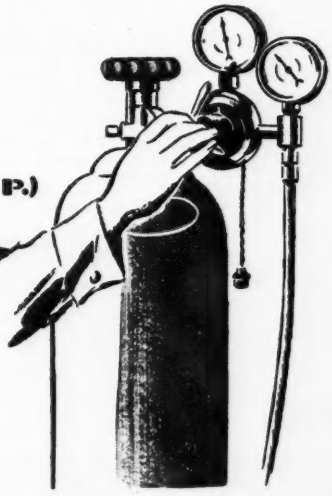

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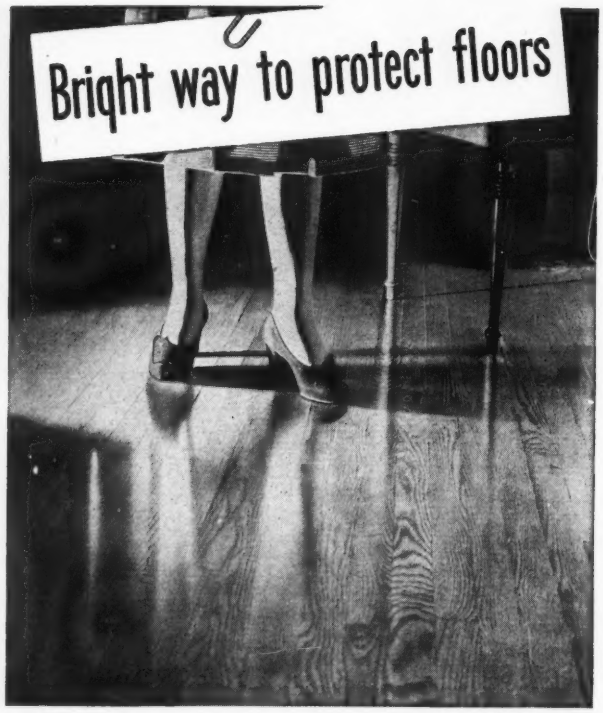


Use Long-Lasting Johnson's Wax

Floors show less wear when they wear genuine Johnson's Wax. The finish is guarded by a gleaming coat of wax. No other floor polish gives such shining beauty, such long-lasting protection. That's why more floors wear Johnson's Wax than any other floor polish. Floors protected with Johnson's Wax are easy to keep clean and sanitary. And regular care with genuine Johnson's Wax may mean your floors will never need costly refinishing. Two types to choose from:

Johnson's TRAFFIC WAX

Genuine buffing wax for heavy traffic areas – paste or liquid form. Famous for the high, bright lustre, and tough film of protection it gives wood floors, linoleum, furniture and woodwork.

Johnson's NO-BUFF Floor Finish

(GREEN LABEL)

Beautifies and protects large floor areas. Just apply and let dry. No rubbing or buffing needed. It shines as it dries. For wood, linoleum, asphalt tile, terrazzo, etc. Brown label NO-BUFF has an extra water-resistant property.

1521

FAMOUS JOHNSON'S WAX POLISHES

S. C. JOHNSON & SON, LTD., BRANTFORD, CANADA

Across the Desk

By C.A.E.

Why Paint Peels

That old, but still quite common, idea that paint is of poor quality if it peels off the surface to which it has been applied usually just isn't so. On the contrary, an oil paint which does not peel when it ought to peel isn't worth using in the first place.

Look at it this way. The main cause of peeling can be traced to moisture in the object being painted. Eventually, one way or another, that moisture has to come out. To escape it must either pass through the paint film, or it must push the paint film out with it, causing peeling.

Paint which doesn't peel under conditions like that is simply paint which is so poor that the moisture passes clear through it—and if moisture can pass through the paint film on the way out, it can pass equally freely through the same film on the way in. Paint which allows moisture to pass through it isn't doing the job for which it was intended.

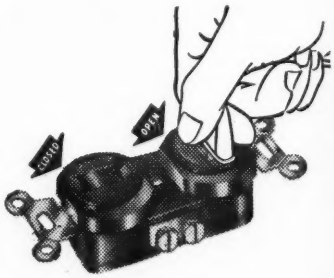
It all boils down to a simple rule of painting. Make sure the object being painted is dry all the way through before applying the paint—and then make sure there is no way that new moisture can get into the object through any part that isn't painted.

—Bulletin of Canadian Paint, Varnish and Lacquer Association.

* * * *

Automatic Closing Twin Outlet

An ingenious twin outlet, "No Shock", which will eliminate the danger of fire and tragic accidents is now on the market. When the plug is removed, the cap closes with a snap-back spring action, thus giving full protection to children and adults—protection that present ordinary outlets cannot provide. Closed caps keep terminals dry and dust free, prevent insertion of hairpins, scissors, wires, etc., into prong slots, thereby causing short circuits, shocks, burns, and loss of life.



Only No-Shock provides thick double bakelite walls separating and insulating heavy duty, current carrying terminals, lifetime spring action and positive contact always. Receptacles and plates are polarized, the plates are flexible and will not crack easily.

Verd-A-Ray Electric Products Limited, Montreal, are the distributors.

* * * *

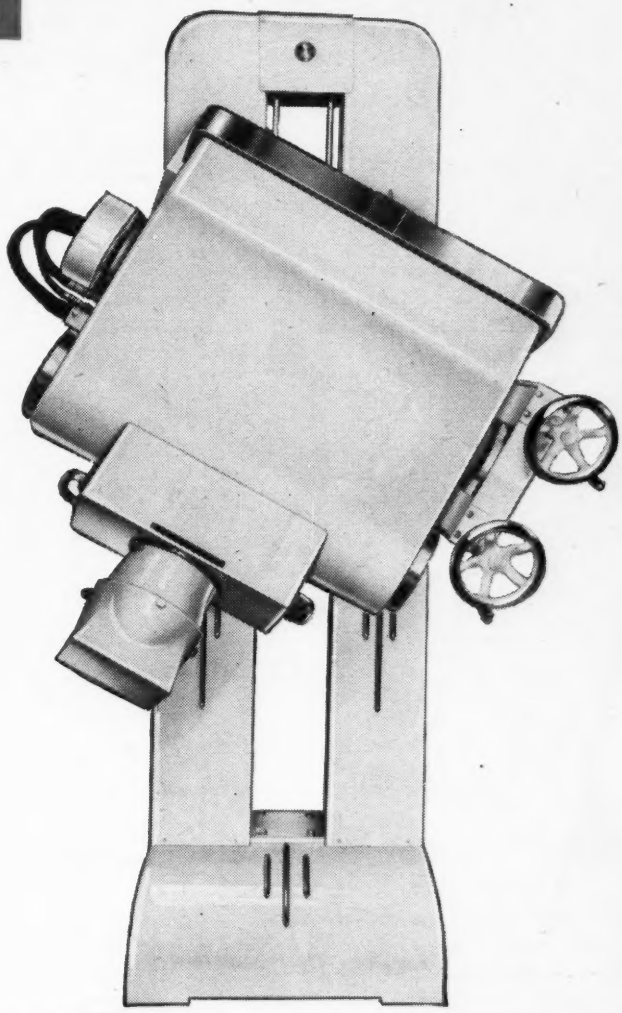
Useful New Booklet on Cleaning

A valuable instruction booklet dealing with the many uses of a new soapless detergent cleaner—Arctic Syntex

(Continued on page 16)

NEW...

THE KELEKET
250 KVP - 15 MA
THERAPY UNIT



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Maximum radiation intensity.

For the treatment of deep, intermediate or superficial lesions . . . here's the latest from Kelley-Koett.

The self-rectifying x-ray circuit, the vastly improved tube, the new, light, compact tubehead and the mechanical flexibility of the tubestand permit safe, accurate manual manipulation of the x-ray beam. (Vertical motion motor driven, if desired.) The 250 KVP-15 MA Unit is easy on the operator as on the patient. The x-ray beam may be focussed to various affected parts of the body without the usual compromises in positioning the patient . . . really meets the heaviest demand of busy therapeutic centres.

Vertical Panel Type Control assures precise setting and control of techniques for complete therapeutic range.

For complete detailed information, write to any Office of X-Ray and Radium Industries Limited

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Yes, Arctic Syntex "M" gets results customers praise—yet it costs no more than many soaps.

Try it on wools, flannels, silks, rayons —*any* risky washing job! See for yourself how quickly, how easily it washes —how thoroughly it protects your customers' precious belongings.

Ask your local C.P.P. man for full details, or write to Colgate-Palmolive-Peet Co., Industrial Department.

Quick facts about ARCTIC SYNTEX "M"

- ★ Does not promote felting or shrinking of woolens.
- ★ Leaves delicate colors and fine fabrics free from odor, spots, discoloration.
- ★ Practically eliminates color bleeding, can be used in mild acid or salt solutions.
- ★ Works equally well in hard or soft water.
- ★ May be used safely on garments of open weave, or loosely spun yarn.
- ★ Dissolves quickly—rinses completely.
- ★ Colored silks and rayons stay fresh and clear.

FOR YOUR RISKIEST WASHING PROBLEM... *USE*

ARCTIC SYNTEX "M"

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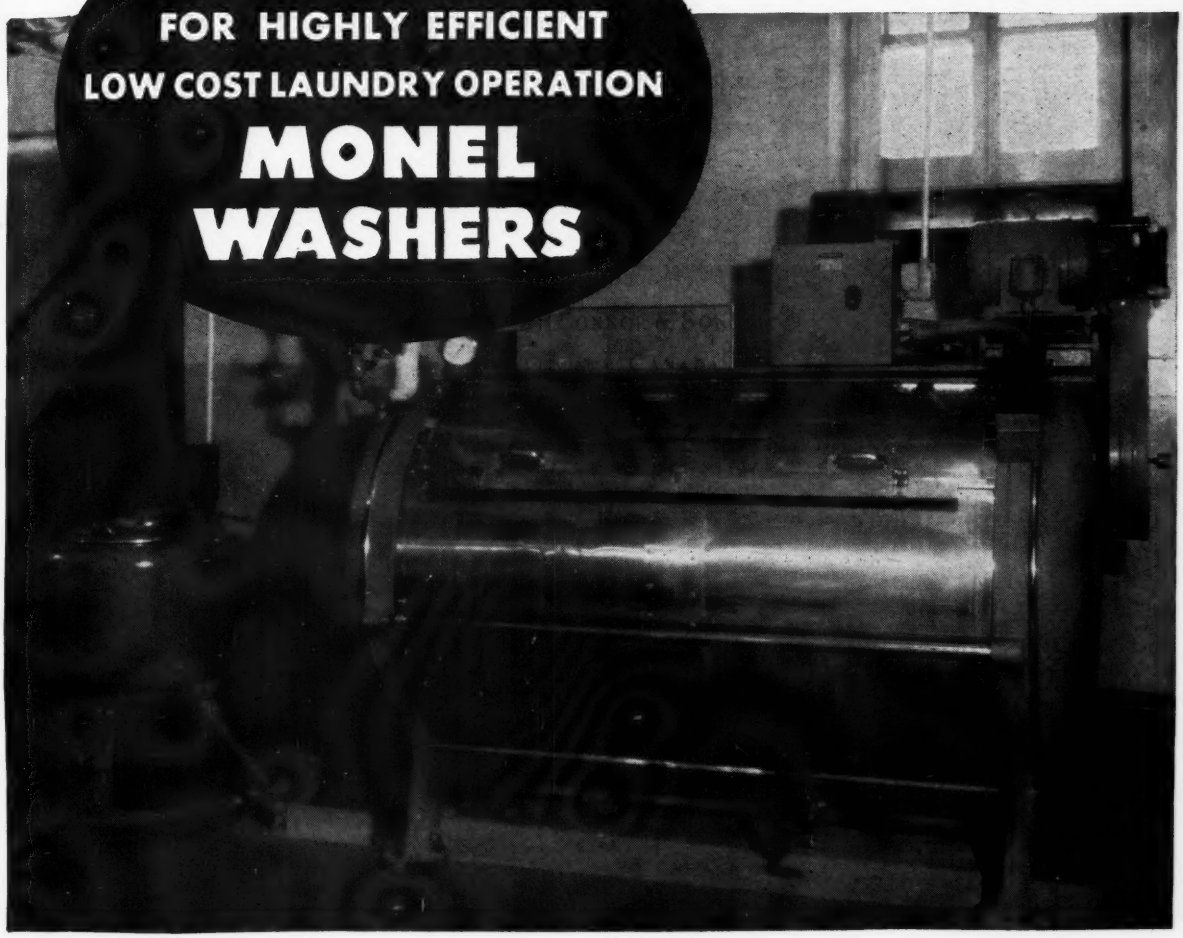
LOW COST LAUNDRY OPERATION

MONEL WASHERS



Since 1942 this Connor Model 6 Monel Washer with reversing motor, and Connor motor driven extractor, have given complete satisfaction at the Convent of Les Soeurs de la Sagesse, Eastview, Ontario. After six years of hard service they still have the appearance and performance of new equipment.

Monel has played an important part in the achievement of to-day's highly efficient, low-cost laundry operation. Being stronger than structural steel, Monel lends itself to the construction of unusually durable equipment. Its high strength-weight ratio cuts cost in power-driven machinery.

Acid sours, dilute bleaches and other supplies used in laundry plant operation do not affect Monel adversely. Monel's hard glass-smooth surface which actually improves with use, eliminates any danger of injury to even the most delicate fabrics and substantially increases the useful life of linen. Too, the attractive appearance of Monel encourages neatness and precision in laundry workers.

For further information regarding laundry equipment please write for our catalogue and price list.

J.H. CONNOR & SON, LIMITED

10 LLOYD STREET - OTTAWA, ONTARIO

WINNIPEG—242 PRINCESS ST. *Quality Washers Since 1875* MONTREAL—4026 ST. CATHERINE W.

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Especially designed for local applications of ultraviolet irradiation.

EAR, NOSE AND THROAT WORK

Many applications in this field.

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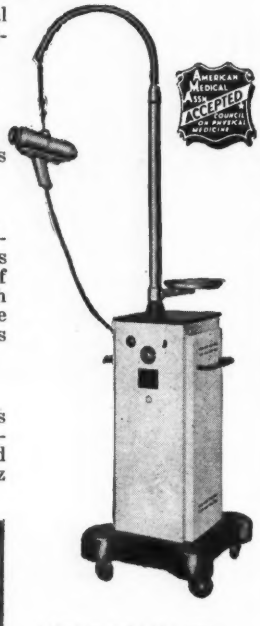
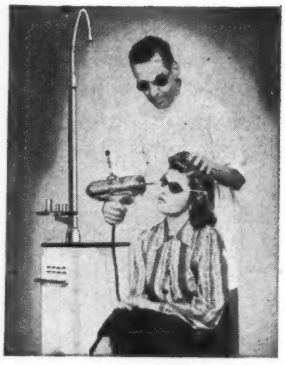
In skin treatment, boils, chilblains, erysipelas and ulcers are the more common of many conditions for which the Kromayer Lamp is the routine measure wherever its value is utilized.

SURGERY

Infected wounds and sinuses are instances of the assistance which surgeons find from due use of focal quartz light therapy.





MORE COMPLETE DETAILS AND CLINICAL RECORDS WILL BE MAILED ON YOUR REQUEST. ADDRESS DEPT. CH-64.

HANOVIA CHEMICAL & MFG. CO. NEWARK 5, N. J.

Hanovia is the world's oldest and largest manufacturers of ultraviolet lamps for the Medical Profession.

Across the Desk

(Contnued from page 12)

"M"—is offered free by the Colgate-Palmolive-Peet Company Limited, Toronto.

Attractively illustrated, and written in simple easy-to-read style, this booklet offers a handy reference source on new and better ways to cover many operations in the washing and cleaning departments.

In addition, dishwashing, fine laundry, maintenance cleaning, upholstery shampooing are all covered in this booklet, as well as many other washing tips that will help operators do a better washing job with Arctic Syntex "M".

Printed in both French and English, these booklets are available for distribution now and may be obtained by writing direct to The Colgate-Palmolive-Peet Company Limited, 64 Natalie Street, Toronto 8, Ont., Department PR-I. Please specify whether French or English copies are desired.

* * * *

Appointments at Hygiene Products

R. G. Daykin was appointed Vice-President at the recent Annual meeting of the Board of Directors of Hygiene Products Limited. Mr. Daykin is also a director of the Company and previously held the position of Sales Manager of the Eastern Division.

R. G. Daykin

H. S. Daykin was elected to the Board of Directors. Mr. Daykin was formerly Manager of the Calgary Branch prior to going overseas as Lieutenant in the R.C.A. during the last war. Returning as Major, he rejoined the Company as Sales Manager for the Western Division.

J. W. Coulson, who was appointed Secreary-Treasurer, was formerly Chief Accountant and Credit Manager.

* * * *

Floor Maintenance

Floors are subjected to more use and abuse than any other part of a building. Representing large investments they are expected to serve satisfactorily for a varying period of years. So, their preservation, sanitation and maintenance is a problem worth careful consideration.

Dustbane Products, Limited, Ottawa, have produced a folder describing various types of Fennell and D. B. equipment for the cleaning, waxing and polishing of floors. Useful information is also supplied on approved methods of treating all types of floors.

Dustbane Products Limited will be glad to send a copy of folder to you on receipt of request.

(Concluded on page 22)

DEPENDABLE SANITATION

YOU may depend
on YOUR particular problem being given specialized study!

YOU may depend
on each product we sell!

YOU may depend
on the integrity of our standards!

YOU may depend
on OUR ability to give YOU satisfaction!

NEUTRALUSTRE the alkali-proof cleaner which cleans as it shines.

SOLVENTOL the new solvent principle cleaner which eliminates rubbing and scrubbing.

ROCKWAX the pure hard-finish lustrous water wax.

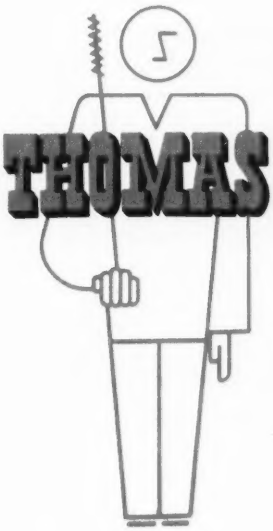
SURGOPLEX the finest in surgical soaps.

VAPORACK double strength deodorant blocks.

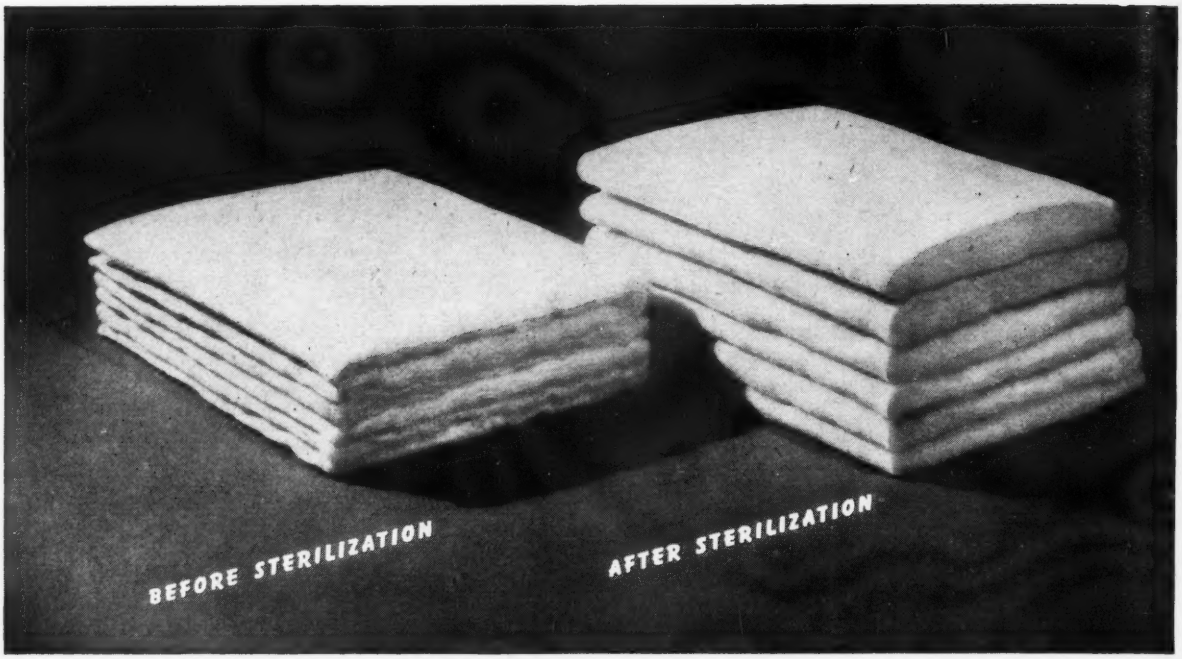
UNIVERSAL souffle cups and drinking cups.

—and other floor cleaning and sanitation products particularly adaptable for hospital uses.

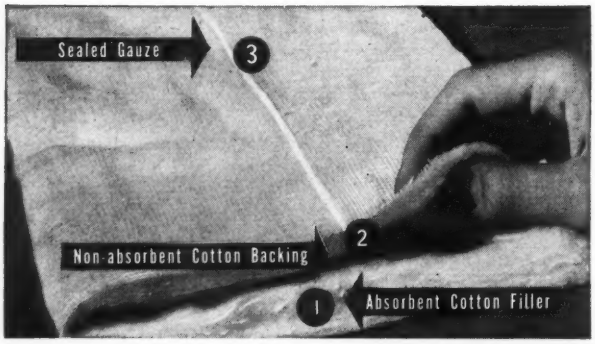
Let US demonstrate OUR dependability to YOU
WE CAN PROVE IT



THOMAS GIBSON & COMPANY
LIMITED
Sanitation Products and Floor Treatments
TORONTO MONTREAL



These all-cotton Dressing Combines improve with sterilization!



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Here is *how* they are constructed . . . *why* they are more efficient:

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That's because J&J Dressing Combines are *all cotton.*

Combines having all or part cellulose filler may *appear* to equal J&J All-Cotton Combines in bulk and "fluff" when taken from the case.

But sterilize both types — and then compare the results.

You will find that J&J Combines almost double in "fluff" when sterilized (see illustration). And that means increased efficiency *at the time of use* . . . extra softness, extra comfort for the patient, greater conformity to the body.

These, with other advantages, make J&J All-Cotton Dressing Combines your best buy!

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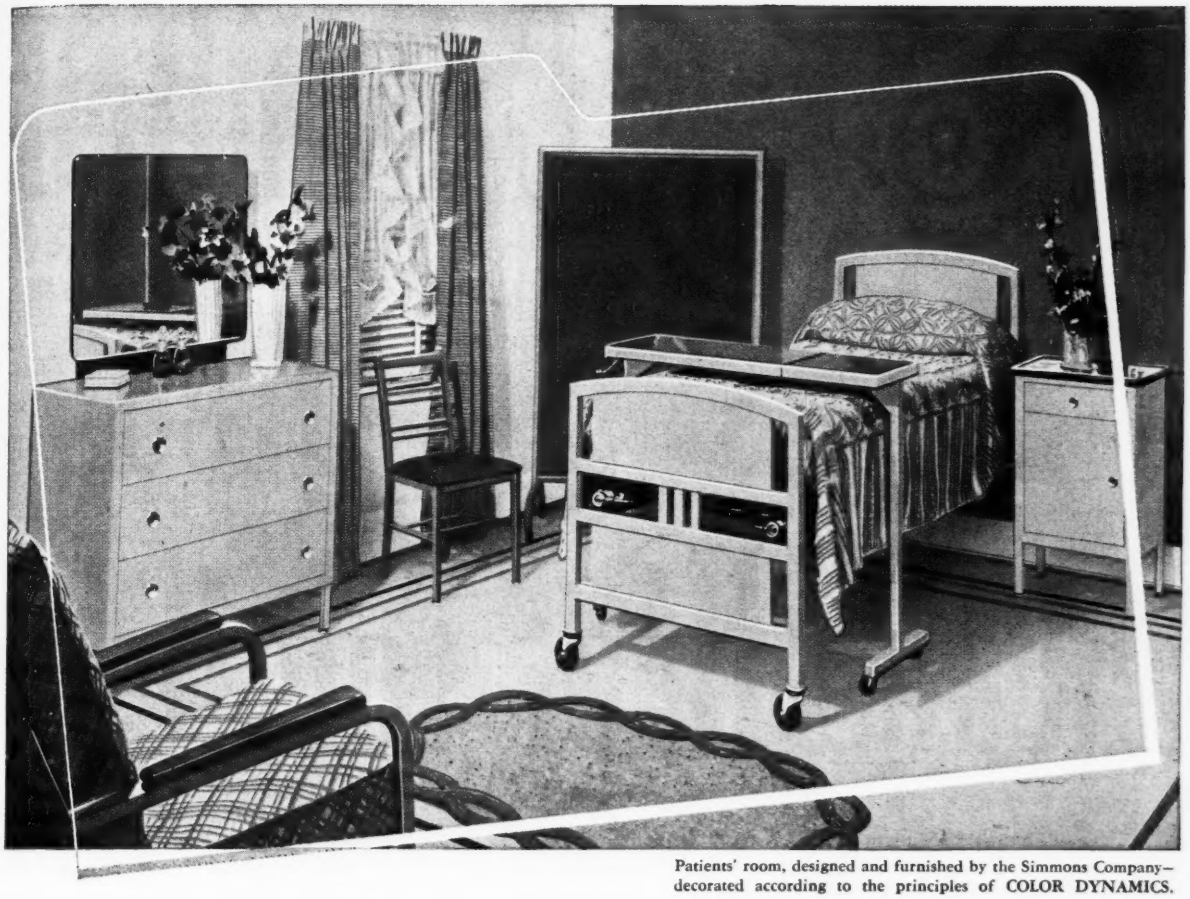

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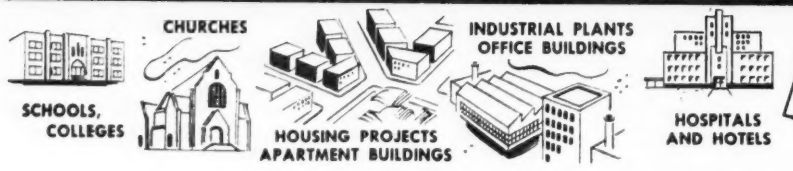

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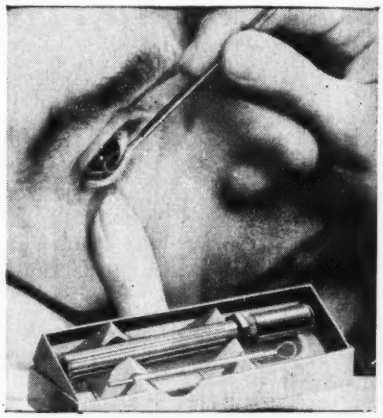
Across the Desk

(Continued from page 16)

Removal of Foreign Bodies From the Eye

Wherever industrial accidents occur, and especially where workers are exposed to flying metallic fragments, filings or other foreign metal substances subject to magnetic attraction, the Eye Sweep illustrated is an indispensable unit of first aid. It is a handy, convenient instrument for clinic, hospital and physician's office.



One end is fitted with a magnet for removing steel splinters, while the other is fitted with a flexible loop for removing cinders, dust and other particles. Sterilization of the instrument will not diminish the magnetic qualities nor affect the loop. A hard rubber carrying case is provided with each Sweep.

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* * * *

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Dew does not fall, it forms in the air from water vapor in the immediate section. . . . Average value of coins minted at the Ottawa Royal Mint in 1945 was 6.6 cents per coin. . . . Ambergris and musk have long been the basic ingredients of perfume and are still on the scarcity list, so two men in Haliburton District (Ontario) are actually milking skunks. They cannot meet the demand for oil of skunk to be used as a perfume fixative. . . . Alaska has some 65,000 sq. miles suitable for farming, yet has only 62 sq. miles under cultivation.

—*The Journal of Institute of Power Engineers.*

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WEAR RESISTANT

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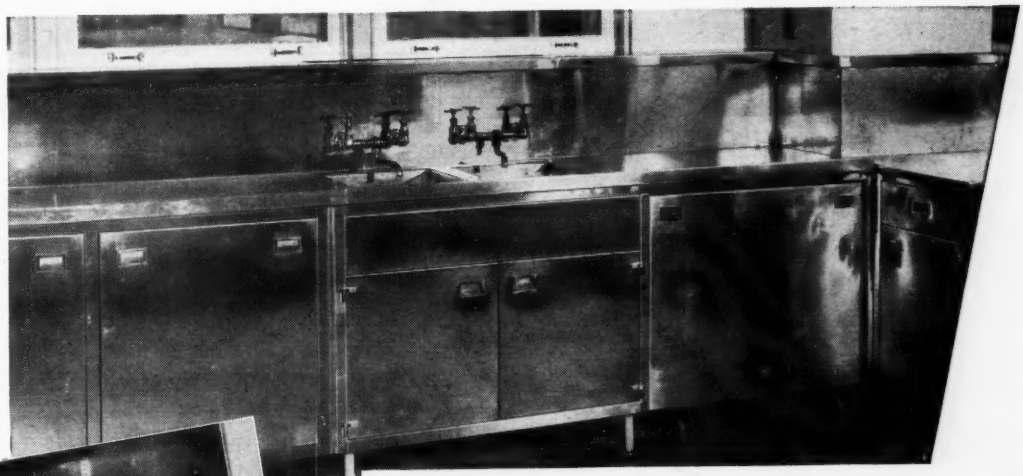

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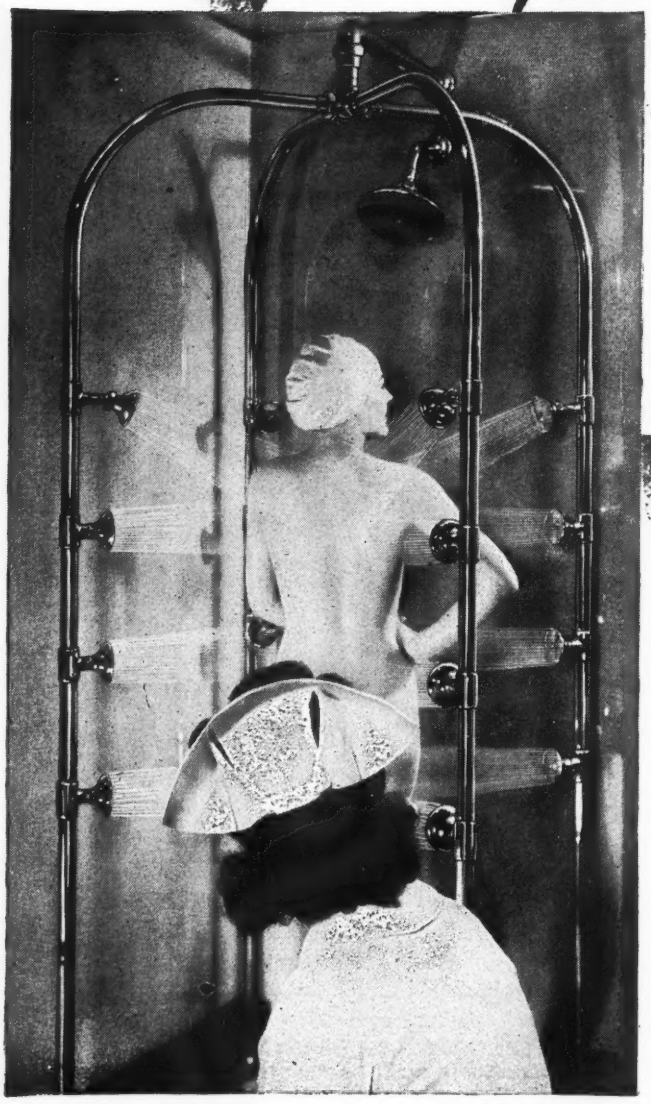
A *Tonic treatment* for nervous cases or circulatory disorders



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Harvey Agnew, M.D., Editor

The CANADIAN HOSPITAL

Toronto, September, 1948 Vol. 25 No. 9

Obiter Dicta

Dr. MacEachern's Anniversary

LAST month Dr. Malcolm T. MacEachern completed twenty-five years of service with the American College of Surgeons. This has been an eventful quarter century for, during that period, more was done to improve the quality of hospital work and the standards of surgery than had been accomplished in any other period. Much of the credit for these higher standards must be given to the American College of Surgeons and the sparkplug for this work through these years has been Dr. "Mac".

We take some pride in noting that Dr. MacEachern is another of those Canadians who have done honour to their homeland in other countries. Born near Lindsay and educated at McGill, he was medical superintendent of the Montreal Maternity and general superintendent at Vancouver General Hospital before going to the College. No one knows how he accomplishes all that he does. Although his A.C.S. work is a man-size undertaking, he has had time to head up the American Hospital Association; to be president also of the International Hospital Association; to organize and still be the centre of the oldest and most valuable annual Institute—the one at Chicago; to be professor and head of the department of hospital administration at Northwestern University; to plan the program each year for the mighty Tri-State meeting in Chicago, the largest hospital gathering in the world; to be president of the Chicago Medical Society; and in between times to write classical papers, give innumerable addresses and write text-books that have become "bibles" in the hospital field.

It is no wonder that he has been invited to many countries, has received honorary university degrees, and was given the A.H.A. Award of Merit in 1939 for his outstanding services. Already he has made more contributions to the development of the hospital field as a whole than has ever been made by any other person in history. May his great work continue!

Relief of Beds by Home Care

ELSEWHERE in this issue the report on home care of patients from the Montefiore Hospital in New York is reviewed. This experiment proved to be highly successful from the viewpoint of relieving the shortage of beds and of providing comfort and care to the patients. The actual cost of providing home care to these patients was less than had been anticipated. Dr. Bluestone is of the opinion that it has been shown conclusively that many patients ordinarily cared for in hospital can often be looked after just as well at home. To quote his article in *Survey*, "Only by a combination of hospital and home care under the same over-all medical management can the hospital employ its unique facilities

in the field of scientific medicine to best advantage."

It must be borne in mind that this hospital is for the chronically ill, which type of patient is more readily looked after at home than is the acutely ill patient. In this connection it is of interest to note that the use of boarding homes for the care of the chronically ill was inaugurated some years ago in Vancouver and proved quite economical, although we are not sure that the medical oversight is as close as at Montefiore. The Vancouver arrangement is described in this issue. Also in New York City many of the patients come under staff physicians; the system could not be applied quite so easily in the case of private patients.

With the high cost of construction some limit must soon be reached with respect to the prevailing custom of "put 'em in hospital". Governments talk of 5 to 8 beds per thousand, but New Zealand set a standard of 10 beds under health insurance and is now increasing that to 13 beds per thousand of population. Our present shortage of beds is forcing early ambulation and discharge, a practice which is proving generally satisfactory to the patient and may well be continued as a matter of policy in the future, although the tendency toward free provision of hospital care will encourage longer utilization. In a recent issue of *Trustee,* Ritz Heerman of Los Angeles noted that the average for the United States in active hospitals is 22 patients per bed per annum. The turnover in Los Angeles is so rapid that the average is 40 patients per bed per annum and, in one hospital, 47 patients.

In the case of active hospital patients, home care under hospital supervision was proved to be both feasible and economical by an experiment a few years ago at Syracuse.* Here, too, the care was of ward patients. For private patients of moderate income, follow-up home care by visiting nurses and, perhaps, by social workers might be done under the supervision of the family doctor, although one would think that, for private patients, a well-organized home nursing service, not necessarily under hospital management might be the answer. Under any circumstances the trend toward earlier discharge would seem to indicate the necessity for a closer relationship between hospital care and follow-up care, be it in a convalescent hospital or at home.

*"*Medical Care of the Discharged Patient", by Jensen, Weishotten and Thomas, The Commonwealth Fund, 1944.*

The Rockefeller Foundation and Current World Issues

THE annual review of the Rockefeller Foundation is always a document worth careful reading. It is more than a record of how a great catalyzing agent in the fields of medical science, public health and social welfare spends its millions. It also gives the philosophy and musings of a great leader, Raymond B. Fosdick, President of the Foundation, whose clear vision and world perspective well fit him to be the head of this unusual organization.

Last year's report is no exception. It is of interest to note that the appropriations last year amounted to the record sum of $23,413,615. Since 1913, the trustees have appropriated a total of $295,896,340 from income and, in addition, a total of $118,010,728 from capital. The highest book value of the Principal Fund was $171,204,624 in 1921; last year the book value was $118,071,816, although the market value was just short of two hundred million dollars.

But one takes especial delight in Dr. Fosdick's comments on the world situation. Little essays on "Challenge and Response", "The Immediate Task", "The Unity of Science", "The Problem of Germany", and "Cross-Breeding of Biology", to name but a few, are gems of thought and literature. For instance:

"The present is one of the supreme moments of challenge, in which, as Toynbee says, the character of our response determines the chances of survival. The past is littered with the wreckage of nations and empires which tried to meet the crises of their times by physical means alone. Our response today cannot be confined to this lower level. Unless we can rise to greatness and lift our answers to an intellectual and ethical plane, our fate will be the fate, not only of the nations that preceded us in history, but of all species, whether birds or brontosaurs, which specialized in methods of violence or defensive armour."

Or this further observation on a timely topic:

"Another aspect of the difficulty which we face in placing on a higher level our response to the challenge of our time, is our superstitious reverence for the physical sciences. They have become sacrosanct—the dispensers of the gifts of life. The doctrine that 'civilization can be bred to greatness and splendour by science' is widely accepted. Even our universities have succumbed to this twentieth century worship of methods which give mastery in the physical world. In contrast with the money available for the humanities and the social studies, far greater sums are today being allocated to the physical sciences by our educational institutions than ever before . . . Of course, a decent obeisance is always made in the direction of the humanities and the social studies. The fact remains, however, that in terms of endowment, research facilities and teaching staffs, these studies are far outdistanced by the physical sciences, and the gap is growing wider.

"But the gap should be closed rather than widened. We cannot escape the obligation, in this scientific age, to comprehend science; but in the supreme question which faces our generation, physics and chemistry and engineering have no answers for us. They are ethically neutral. They are preoccupied with physical matter. They can give us more horsepower; only the naive, however, will claim that horsepower can develop within itself the means by which our runaway technologies can be brought under control. They can help more men to better health and longer life; but they have little relationship to the problem of discovering a new set of human purposes, or to the art of human relations, or to the winning of social and moral wisdom, upon which peace and successful government depend . . .

"The issues of our time and of human destiny will be determined, not at the physical, but at the ethical and social level. Material power and dollars and military ascendancy may preserve us temporarily; but the dynamic tensions of our society can be relieved only by moral and social wisdom, and that kind of wisdom cannot be precipitated in a test tube nor can it be won by the brilliant processes of nuclear physics."

Dr. Fosdick believes in international co-operation. "In the history of modern science no single country by itself has ever had the intellectual resources or the imagination to bring to full fruition all the potentialities of a new idea." Again, "Ideas are starved when they are fenced in behind frontiers, and barricaded research in the long run can result in intellectual stagnation."

Better Opportunities for

Training Hospital Administrators

J. Gilbert Turner,
M.D., C.M., M.Sc. (Columbia),
Superintendent,
Royal Victoria Hospital,
Montreal.

HOSPITAL administrators generally fall into one of three groups: those who have or have not a degree (other than medical); those who are registered nurses; and those who are physicians. I am not one who believes that every hospital should be administered by a doctor. There is a very great need for members of all three groups. The needs of the individual hospital, its size, its resources, and other local factors, determine which group should be the source of the administrator most likely to contribute the greatest service.

A degree in hospital administration, or in any other faculty, does not ensure that the recipient is a good administrator any more than the conferring of an M.D. degree guarantees a good doctor or the granting of a licence to teach promises a good teacher. In each case, the faculty can go no further than satisfying itself that the candidate has been reasonably well instructed in the fundamentals which will act as a broad base upon which the day-to-day experience might be built.

There is no doubt of the value of the apprenticeship method of learning hospital administration—if one is fortunate in his teacher. As a matter of fact, without such instruction formal education in the field is almost valueless. One cannot learn about staff relationships from a book or by listening to a lecture. As we all know these relationships are a very part of our every day life. There are many other phases of our routine which are in the same category.

At Graduate Level

With present day trends towards longer and longer training for the professions and vocations, it is not surprising that the training of hospital administrators should be the subject of critical review by leaders in the field. Formal training has been in effect in two centres since the early 30's but it is only since 1945 that a considerable number of additional courses, at the graduate level, have been offered in recognized universities. The number of applicants has far exceeded the educational facilities available because of the demobilization of so many persons who, through the exigencies of war, have had considerable experience with hospital activities and are attracted by the great possibilities in this new field. Preliminary reports bear out the fact that these people are making a very definite contribution at a time when the need is urgent. First classes were unduly large because the universities were anxious to expedite the rehabilitation of service people. It is quite possible that the number of applicants will be reduced so that the various faculties will be able to accept smaller classes. It would seem that twelve should be the maximum number for a class in hospital administration because it is essential that there be close relationship between instructor and student and between one student and another.

Dr. J. Gilbert Turner

The requirements for entrance to such a course must be carefully established. The responsibility of the admissions committee of each faculty is very great. I believe that there can be no argument as to the wisdom of maintaining such a course upon the graduate level. But in addition to a degree—whether that degree be a Bachelor's degree, a Master's or a Doctor's, in the arts, the sciences or the professions—what other requirements are necessary? Certainly the first is an intense desire to work in the new field and the willingness to sacrifice personal pleasures for service, not only during the training period but throughout one's career. There are many other personal qualities which should be required but there is no need to enlarge upon them now—they are too well recognized.

How is the admissions committee to satisfy itself that the otherwise desirable candidate has the spirit of service and sacrifice? I see no way except that the applicant must have had some actual experience in a hospital under a competent administrator who is prepared to certify that the student will, so far as he can determine, do a good job in the hospital field. Such a period of on-the-job experience should not be less than six months. In fact it may well be a year and during this period the candidate should follow a definite program and be reimbursed for his efforts. If recommended, he could then proceed to the university course of two years which includes one

An address delivered to the Hospital Conference of the American College of Surgeons, Halifax, N.S., 1948.

year's residency. Following the period of residency, the graduate should have the benefit of further experience in the role of assistant administrator before taking over the very onerous responsibility of directing his own hospital.

While the present program of training on the graduate level has produced a great number of new people for immediate service in the hospital field it is nevertheless geared to the long range view of training. For that reason the universities presently participating in the program are on solid ground when they state that they will be training fewer students, now that the post-war demands of both hospitals and students have been met to a considerable degree.

Courses for Non-Graduates

What of the immediate need for training people who have no university degree, who have no hope of obtaining one and yet are qualified otherwise to render a very definite service to the field? I refer to the many nurses and key personnel with considerable hospital experience who are very keen to improve their lot and to take over eventually the responsibilities of either assistant director or director of a hospital. Time does not permit the average administrator to conduct a formal training program for a few people in his organization. Collateral reading could be arranged. Institutes conducted by the American Hospital Association and by other bodies of similar standing are most commendable but no week's training makes an expert.

Should there not be made available to these worthy people some formal instruction on a basis similar to that of a graduate student? If so, where could it be conducted? The facilities of the university and the teaching hospital should be enlisted for this instruction, as they are for the present courses on the graduate level. A certificate could be granted at the end of the academic year at which time the recipients would be encouraged to return wherever possible to their own hospital, at least for a period, so that the hospital could receive some benefit from their training. Internship would not be required since the whole aim of the plan is to train as great a number of people, in as short a time as possible, in the fundamentals of hospital administration. Those who have neither degree nor previous hospital experience should spend a minimum of two years in hospital service before they could be admitted to the certificate course.

Do I hear that a year is too long? I assure you that it is all too short. Anything less would not be worthwhile even in dealing with students who are not entirely new to the field. If I may be permitted to call upon my own experience, I found that some thirty hours per week of lectures, seminars and field trips, supplemented by twenty or more hours of home work per week were not sufficient to acquire more than the fundamentals and administrative aspects of the many subjects covered in the course. The carefully planned residency of one year was of inestimable value in adding practical experience to the theory of the previous year.

Continuous Learning

No matter at what stage of his career, the administrator as well as the intern should not be unmindful of the many avenues by which knowledge can be increased and experience gained. Certainly he must know his hospital and the key personnel and see them frequently.

He must know something of the community pulse which he can learn by engaging in a limited number of well chosen community activities, both within and without his field. He should attend the local, regional and national meetings of the hospital association—first, because he should actively support these bodies; second, they afford relief from the daily grind; third, they are instructive, whether one is a lone listener or just one of dozens (or hundreds).

I hesitate to say that he should read all the current literature of the hospital field. The paper war shows no signs of lessening. At least, he should acquaint himself with the incoming literature and note certain articles for future study.

We require some degree of adequate preparation for the professions, the vocations, the trades. Hospital administration should be no exception. I favour the combination of apprenticeship plus formal instruction by sound experienced teachers. The administrator must be properly prepared to meet the heavy responsibility, on the one hand, of giving a satisfactory account of his stewardship to his governing board and, on the other, of maintaining the efficient functioning of an organization which is geared primarily for the care of the sick. He must, among many other things, study every request and make his decision, not from the degree of enthusiasm which accompanies it, but in the light of actual and relative need and the extent of the hospital's resources. He must often say "no" but in so doing he must make it quite clear *why* he says "no". He will thus create in his staff, professional and non-professional, a feeling that he is guiding their best efforts toward one common goal, the welfare of the patient. He, and each member of the staff, must learn to understand the point of view of the other. In tolerance lies the possibility of greatness.

Are You Attending Institute at Vancouver?

A busy week of lectures and discussions is being planned by the program committee, under the chairmanship of George E. Masters, for those attending the Western Canada Institute for Hospital Administrators and Trustees. The Institute will be held at the Vancouver Hotel, October 4th to 9th, and lecturers will be present from both Canada and the United States. You are invited to attend, to ask questions, and to take part in the discussions. The registration fee is fifteen dollars per student which includes the special dinner on the evening of the 6th. Applications should be addressed to Mr. Percy Ward, general secretary, 129 Osborne Road East, North Vancouver, B.C.

Golden Jubilee Celebrated at St. Mary's Hospital, Dawson

ST. MARY'S HOSPITAL, one of the oldest and most valued institutions in the Yukon, "Land of the Midnight Sun", this year celebrated its Golden Jubilee, marking fifty years of service and expansion. This modern, well-equipped hospital, accommodating 100 patients, is a far cry from the original two-storey log structure. The first hospital was hastily erected in 1897 by Reverend William Judge in an attempt to relieve the suffering and distress of the hundreds of men and women who had braved the perils of a rugged land during the Klondike Gold Rush. These were the people who pitched their tents on a shelving flat and witnessed the birth of the City of Dawson.

The task which Father Judge set for himself seemed almost impossible, especially in the face of an epidemic of typhoid fever, but in the spring of 1898, assistance came. Dr. W. T. Barrett from the South and six Sisters of St. Ann from Holy Cross Mission, were among the first to arrive. Unfortunately, the herculean tasks undertaken by Father Judge had taken toll of his physical reserve, and he succumbed to an attack of pneumonia the following year. On a hillside overlooking the City of Dawson stands a monument telling of the esteem and reverence with which this valiant man is remembered.

After the death of Father Judge, the Sisters of St. Ann became re-

Staff Sisters in the Jubilee Year, 1947-48

Front row: Sister Mary Pudentienne, Sister Mary Mark, Superior.

Second row: Sister Mary Barnabe, Sister Mary Annee, Sister Mary Anthony.

Third row: Sister Mary Gedeon, Sister Mary Clementia, Sister Mary Walter.

Upper row: Sister Mary Laurena, Reg. N., Sister Mary Elie Anicet.

Sister Mary Pudentienne

Sister Foundresses of St. Mary's Hospital, 1898

Lower row: Sister Mary Pauline, Sister Mary Zephyrin, Superior, Sister Mary of the Passion.

Upper row: Sister Mary Pudentienne, Sister Mary Joseph Calasanz, Sister Mary Jean Damascene.

Reverend Sister Mary Mark, Superior

sponsible for the upkeep and development of the hospital. To-day the crude building with its beds of grass-filled ticks, its wood stoves, packing boxes that served as tables, has been replaced by an up-to-date, modernly equipped institution serving a large area.

The first step in the expansion of the hospital was in 1898 when a three-storey addition was built to meet the exigencies of the typhoid fever epidemic of that year. In 1906 the original building was replaced with what is now the main section of the hospital. However, this building received little new furniture or equipment, and the decreasing need for hospital service made further expansion impractical until about 1935. Since that date the demand for accommodation has increased and in 1940 the maternity section was extended. In 1942 the kitchen department was enlarged and a children's ward added. A section for tuberculous patients was erected in 1944 and on July 11th of this year, the Jubilee Extension was formally opened.

St. Mary's provides a composite service to the people of this area. Besides caring for emergency cases and the critically ill, it maintains a psychopathic ward, an old-timer's section which is at present filled with about thirty elderly men who have given their youth and vigour to the country, and an Indian Service Department. The new extension will provide an isolation section, relieve congestion in the medical nursing section, and provide needed space for hospital auxiliaries.

The funds for additions to the hospital have come from fund-raising projects, from the people who have had reason to know and appreciate the hospital, and from the Territorial Government which has given regular assistance.

At the Jubilee Ceremony, those who pioneered and gave their services in this rugged northland were specially remembered. Tribute was paid to Father Judge, to Dr. Barrett, to the Sisters of St. Ann, including Sister Mary Zenon, superior of the hospital from 1899 to 1909, to Sister Mary Pudentienne who was one of the Foundresses and who, in her eightieth year, was present at the ceremony.

Among the Jubilee guests were: The Most Reverend J. L. Coudert, O.M.I., Bishop of the Yukon; The Most Reverend Francis D. Gleeson, S.J., Bishop of Alaska; The Very Reverend Father Leo Deschatelets, O.M.I., Superior General of the Oblate Fathers who went to Dawson in 1898; Reverend Father McElmeel, S.J., Missionary in Alaska for many years; Reverend Mother Mary Ludovic, Provincial Superior of the Sisters of St. Ann; Sister Mary Dorothea, her secretary; Sisters Mary Henrietta and Mary Rose Eva, former Superiors of the hospital.

Above: Dr. W. T. Barrett, physician and medical director in Saint Mary's Hospital in 1898.

Left: Rev. Mother Mary Leopoldine, S.S.A., present Superior General.

Those Medical Records

Are they accurate, up-to-date, and complete?

G. W. J. Fiddes, M.D., C.M.,
Medical Superintendent,
Brandon General Hospital,
Brandon, Manitoba.

EVERY mariner appreciates the value of a sailing log. Therein is the record of the going and coming of his ship. There is the story of voyages, new experiences, changes of course or cargo and the report of many safe home-comings. His log is his book of learning. From it the unwary is warned and the master may therein teach the apprentice. In several ways the medical records of a hospital should serve a similar use to benefit the physician, the intern, and the patient.

The American College of Surgeons has concisely stated that *"hospital medical records should be accurate and complete, promptly written and filed in an accessible manner so as to be available for study, reference, follow-up and research"*. It would be difficult to state the qualities of a good medical record in any better manner. The demand for this high standard need not call up before us visions of large bundles of closely-written pages nor of midnight hours spent in copying histories. This punishment was rightly reserved for the discipline and enlightenment of junior interns. The essentials of good records are clarity, vital information and brevity. Wordy or unimportant dissertations have no place in the hospital record. Too much may be almost as bad as too little when search is made for the all-important diagnosis, the complication or treatment. The fact that the patient's grandfather had gout may be an interesting finding. It may even be of considerable value to the family physician, but it has little place in the record of a general hospital.

Whereas the patient's record should contain only essential information, this can best be compiled by making use of standard forms. In common practice the chart from front to back should be made up of admission sheet and history, doctor's orders, T.P.R. sheets, nurses' notes, and thereafter all routine or special departmental reports.

Essential Features

The medical history may take any of a variety of forms but I think we may agree that the preferable form is one which contains all important or useful information without being complex or voluminous. It must be recognized that a busy physician's time is extremely valuable.

In Dr. Logan Clendening's book *Workbook in Elementary Diagnosis*, the author makes good use of a quotation from Rudyard Kipling:

"I have six honest working men,
They serve me 'till I die;
Their names are Who and What and When
And How and Where and Why."

The answers to all these questions should be found in the case history. The model form is never intended to limit the amount a physician may wish to write, and follow-up sheets should certainly be available.

The first sheet or information record usually answers the first three of the six questions mentioned in Kipling's verse. *Who* is answered by the name and address, occupation and near-of-kin entries concerning the patient. This information is of definite legal and financial value and its importance does not need to be stressed. The question *What* may be answered by the provisionary or preliminary diagnosis given by the physician. "What is the patient's reason for entering hospital?" The answers may vary all the way from birth to senility, from a fully scientific diagnosis to an admission that "something is wrong and I don't know what." The diagnosis may not be complete, the information only sketchy, but above all it should be honest and couched in good terminology. Twenty years ago "Inflammation of the Lungs" was a perfectly satisfactory diagnosis. However, a modern physician may be able to decide whether this is pneumonia, bronchitis, tuberculosis, or something more obscure. In so far as it is possible, all diagnoses made on hospital charts should conform to the standard nomenclature listed in approved books on diagnosis.

The question *When* refers to the date and time of admission. This is straight-forward information often important in settling insurance claims. Not infrequently it assumes great importance in medico-legal cases where the exact time of an accident is not otherwise established.

The three other questions in Kipling's verse pertain essentially to the medical history. *How* should describe the care of the patient, diagnostic procedures and reports, medical and surgical treatment, nursing notes and everything which may answer the question, "How is the patient treated?" *Where* may be used to define very specifically any operative findings or observations which limit the condition to one area, system or member. It is to be remembered that insurance or compensation is never paid to the patient, hospital or physician, unless the right or left side is noted when disease or injury is unilateral. *Why* is meant to summarize the progress of the patient. It is often just as important to explain why a patient recovered as to excuse ourselves if he did not. For the inquisitive student or intern, and certainly each should be, any record describing why a certain routine improved the pa-

(Continued on page 74)

"Since the days of Hippocrates and all through the centuries of growing medical knowledge, contributions to the healing art have been made largely through the written word."

Organization and Control of the STORES DEPARTMENT

S. W. Martin,
Assistant Superintendent, Toronto East General and Orthopaedic Hospital, Toronto.

WHEREVER new hospital construction is contemplated, or wherever additional construction to already established hospitals is undertaken, more and more thought is, and should be, given by the architects and consultants to adequate space for storage facilities.

The physical set-up planned for the storage of the manifold items required for use in a modern hospital deserves the most careful attention. Inadequate provision of storage space provides many a wrinkle or grey hair for the conscientious administrator, and more and more so in this province since the introduction by the Provincial Department of Health of standardized accounting and cost schedule forms. Half-way methods in the control of supplies will inevitably contribute to inefficient buying, to lack of proper supervision over departmental use of supplies, and to intrusion by irresponsible persons.

The first step is to determine some measure or equation to relate adequate storage space to the size of the hospital. While it is true that the area will vary with the bed complement of the hospital, other factors must also be considered, such as location of hospital, type of hospital, and proximity to sources of supply.

What supplies are to be controlled in the central stores must also be determined. Accepted practice appears to dictate that the following items should be included:

Food;
Medical and surgical supplies (including instruments);
Linens and bedding;
Printing and stationery;
Miscellaneous house supplies: (soaps, cleaning fluids, mops, et cetera, miscellaneous furnishings, paper goods of all kinds);
Kitchenware, including pots, pans, dishes, glassware, and silverware;
Maintenance supplies.

To the above in special instances might be added pharmaceuticals and engineers' supplies, but control of these items presents certain operative difficulties, such as very specialized training in handling or ready availability twenty-four hours a day. These articles quite properly should be received in the central stores, but will no doubt be immediately passed on to the pharmacy or the engineers' department.

Surmising that our central stores is to care for the first group, it would appear that a minimum of twenty square feet of floor space per bed should be provided for storage. This space, if at all possible, should not be in segregated or partitioned rooms, but should be free area between four walls.

From this it may be seen that a hospital of 300 beds should have available some 6,000 square feet. To provide this area entirely on one floor would require a considerable amount of space, and it would therefore appear advisable to think in the terms of a separate building of two floors. In practice, such a set-up would appear to provide several advantages, such as:

1. A separate entrance to the hospital for all tradesmen. This is a most important factor, particularly in the larger hospitals;

2. Control of entrances from the hospital to the storage facilities;

3. Separate quarters for bulk storage and readily available stores for daily issuance;

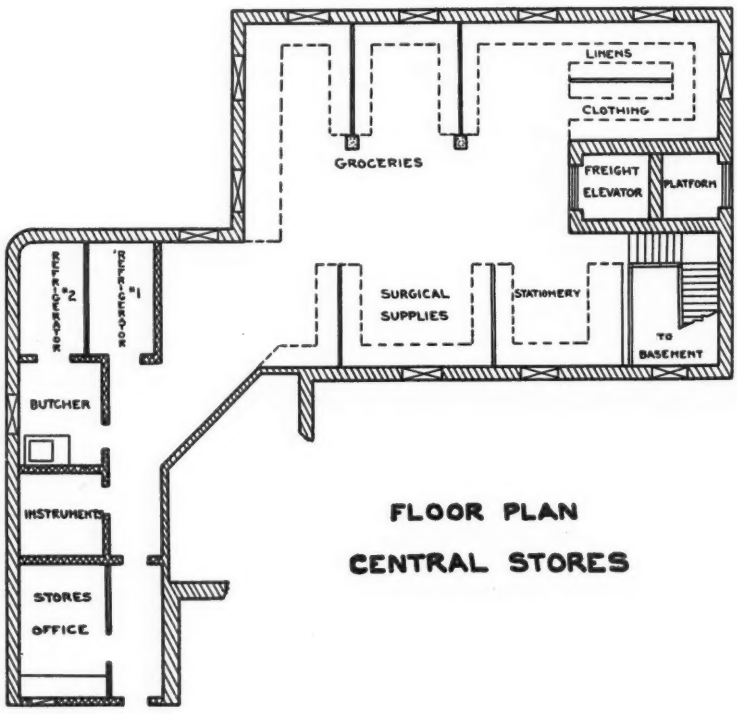


Figure 1

An address presented at the Ontario Institute for Hospital Administrators and Trustees, London, in April.

STORE ROOM CHARGES

DEPARTMENT

memo	date	req.-pur. No.	charges	dietary charges	drug charges	surgical supply	credits	balance	pick-up

Figure 2

4. Economy in overhead for handling of supplies.

Lay-out of Stores Department

As noted before, the planning of your storeroom is most important. Various kinds of supplies and equipment can best be stored and handled through installation of different types of shelving, bins, cabinets, or cubicles. A careful study of the materials to be handled will assist greatly in selecting the type of installation which will result in maximum utilization of all the floor area available for storage purposes. Actually, the space required for a well organized storeroom will vary according to the care which is taken in planning the shelf space to fit stock requirements and buying policy.

A general lay-out with proposed shelving is shown in the accompanying illustration (figure 1), indicating shelves arranged along outside walls and extended towards the centre of the room in sections. Such an arrangement leaves the important centre section of your storeroom floor clear for traffic and necessary passage of large pieces of equipment. With a two-storey building, it is possible to plan the receiving platform directly in front of a two-storey lift large enough to carry at least a two-ton load. The receiving platform will be on a level, approximately half-way between the two floors, making transportation to reserve stores floor or active stores floor very simple.

Items such as canned goods in cases, surgical dressings in cases, china, bagged goods, such as flour, sugar, et cetera, will be initially stored in the ground floor and withdrawn to the active stores as the shelves become empty. On the floor set up for active stores, will be installed definite sections assigned to dry groceries and canned goods, surgical and medical dressings, stationery, office supplies, paper goods, cleaning supplies, linens and bedding.

Refrigeration

Careful thought should be given to the matter of refrigeration. To store perishable vegetables will require refrigeration space; meats and fish, eggs and butter, must also be adequately protected. While standard temperature boxes are satisfactory for vegetables, butter and eggs, the proper storage for meats and fish demands accommodation capable of being cooled down to the zero level or below. In the floor plan demonstrated herewith (figure 1), has been included a section of the stores department for a butcher shop, on the assumption that the final issuing of meats, fish, and fowl will be in their dressed stages. More attention is being given to-day to the problem of fast-freezing units for both the preparation and storage of seasonable fruits and vegetables. For anyone having construction of storage facilities under consideration, careful thought should be given to this type of refrigeration, as it would appear that more use will be made by the hospitals of this type of product in the near future.

Storekeeper and Staff

The location of the storekeeper's office should be so planned as to afford him a view of all persons entering or leaving the storeroom. Access to the central stores from the hospital should be limited to one door and only the storekeeper, his assistants, and one or two members of the administrative staff should be permitted the use of keys. This door should be kept locked at all times and any person having business with the stores department should be received at a wicket, preferably facing into the storekeeper's office.

No matter how perfect the physical quarters of a stores department, efficient service will not be obtained without careful selection of the storekeeper and his staff. The storekeeper must be an individual possessing detailed knowledge relative to the many materials used in the day-to-day work of all the departments in the hospital. Dependent upon the size of the hospital and extent of the stores department, capable assistants will have to be added to augment the storekeeper's staff. From our own experience, it would appear that the operation of a central stores unit to serve 300 beds would require the services of an efficient storekeeper, of departmental head calibre, a capable assistant, two additional clerks, and a butcher. The last noted is optional, depending upon the requirements of the food service department.

While it is the custom in some hospitals to place supervision and direction of the stores department under the purchasing agent, or have the storekeeper act as purchasing agent, reason and practice would suggest that the receiving department should be organized as a separate department responsible directly to the administrator, rather than a sub-

(Continued on page 80)

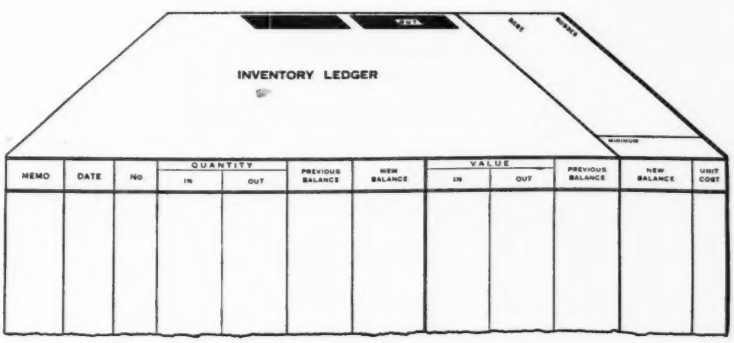
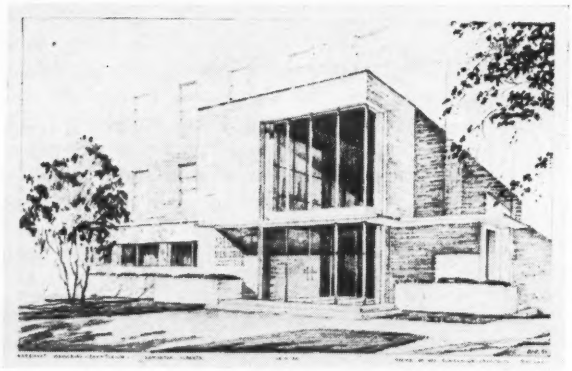


Figure 3



Designed for Alberta Climate

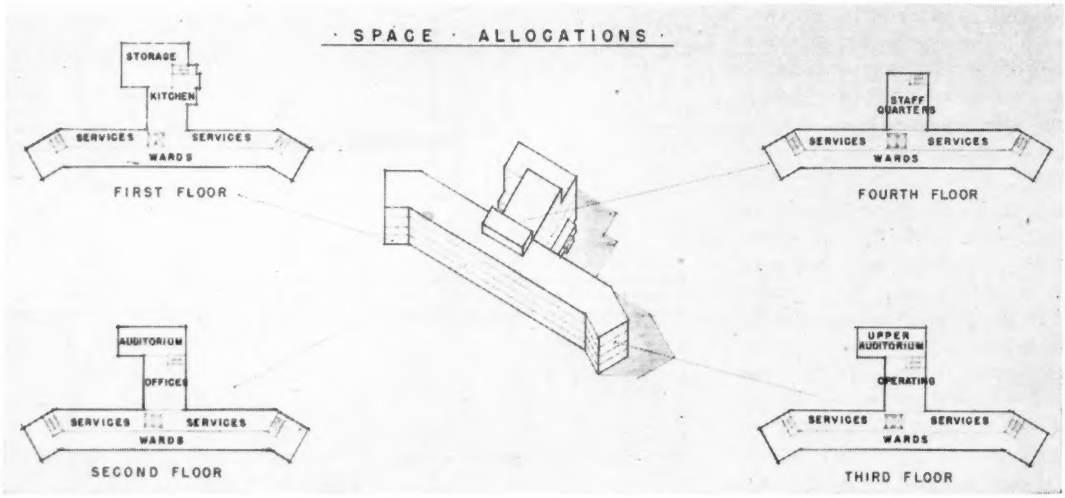
New Aberhart Memorial Sanatorium

CONSTRUCTION will begin shortly on the 250-bed tuberculosis sanatorium on the University of Alberta campus, south of the University Hospital's new residence for nurses.

Since Edmonton is Canada's most northern city, climatic conditions greatly influenced the orientation, planning and materials to be used for this building. Advances in the methods of treatment and care of patients during the past twenty years also called for many departures from the stereotyped open balcony style of building, which is commonly visualized as a "sanatorium". It was also necessary to provide accommodation for patients of all groups, terminal, acute, semi-ambulant and ambulant. This was done by allocating wards on various floors to different groups and placing the necessary services on the same floors. This will provide as much segregation as possible and avoid unnecessary traffic through corridors.

The building is T-shaped in plan. The wing containing patients' rooms runs east and west with all patients' rooms facing south on the south side of a central corridor. Service rooms are placed on the north side of the corridor.

The patients' wing is about 340 feet long with solaria at the east and west ends. Provision is also made for future extension at these points. Open balconies would not be practical in the extreme cold of the long winters nor in the high winds of the Prairies. A sun deck is designed for the roof. Continuous windows on the south provide for a maximum of sunlight and air and make each room actually a solarium. One of the first examples of this type of planning is the Tuberculosis Sanatorium at Paimoni, Finland, designed by the well known Finish architect, Alvar Aalto. Climatic con-



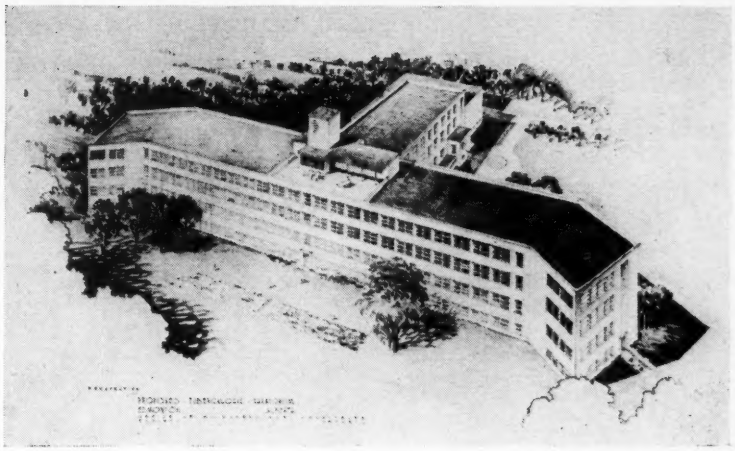
ditions similar to those of our Canadian North-West, no doubt, were a factor in developing this plan.

The north wing, or leg of the T, on the lower floor at grade level contains the kitchen, cafeteria and dining-rooms for staff as well as necessary storage space. The administration offices, main entrance lobby, auditorium, doctors' offices, record office, x-ray and physio-therapy rooms are on the floor above. The upper floors are planned for operating suite, aspiration room, fluoroscopy, dental surgery and other similar services. At the north end of the wing on this floor and the floor above, living quarters are provided for the staff.

The auditorium is planned to serve a dual purpose. It is placed at the extreme north end of the north wing and is a storey and a half high with stage and dressing rooms suitable for simple theatrical performances or concerts. It has also a screen, and fully equipped projection room which can be used for full length commercial sound films. Accordian partitions are provided so that the auditorium can be divided into sections and used for occupational therapy groups.

Two elevators serve all floors including the sun deck on the roof.

The building will be of fireproofed construction throughout with a steel frame and concrete floor and roof slabs. The exterior walls are to be of brick backed with hollow tile.



The interior will have steel door frames and wood slab doors. Ward floors will be of terrazzo with terrazzo base, while linoleum with terrazzo border and base is to be used in the corridors.

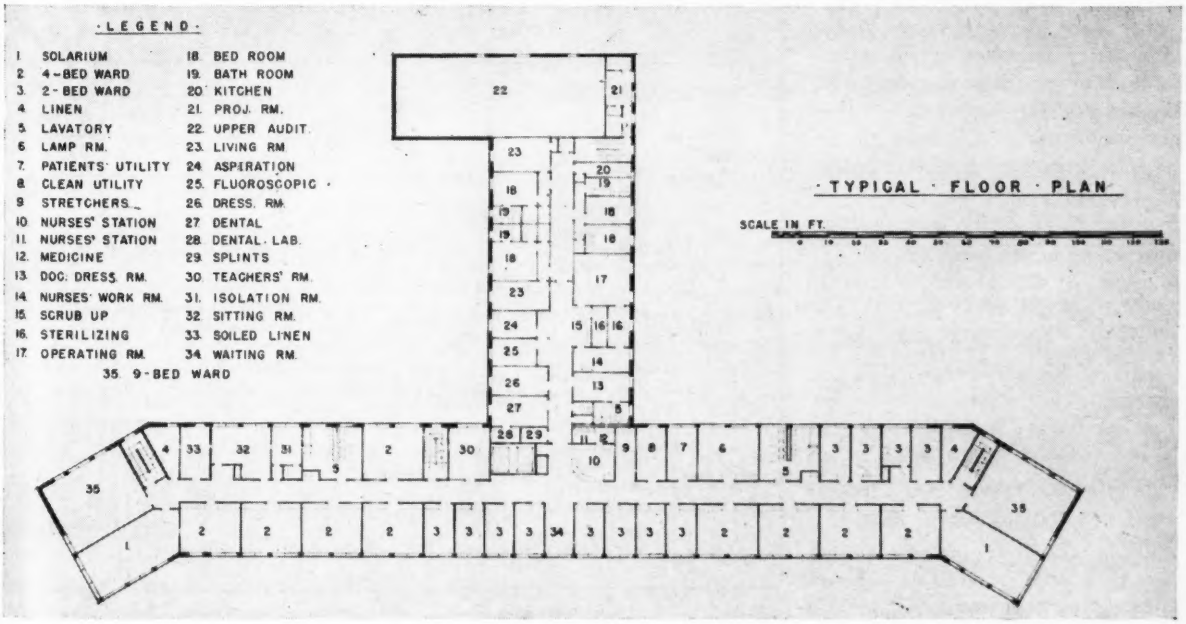
The walls of the auditorium and entrance lobby are designed for wood panelling with concealed and direct lighting.

Special attention has been given to the windows. After careful consideration of all the factors involved, it was decided to use double hung wood sash and frames with double glazing, the sash being hung on spiral sash balances and arranged to pivot for convenience in cleaning. Interior window stools and exterior sills are to be of extruded aluminium.

The sanatorium will be heated from the central heating plant of the University.

The building is being financed by the Provincial Department of Public Health and will be administered by the Tuberculosis Division of that Department. Provision will be made for rotation of interns through the Sanatorium service.

The working plans were prepared by A. M. Brydon under the direction of Arthur Arnold, Superintendent of Buildings, Provincial Department of Public Works, Alberta, with the office of W. L. Somerville of Toronto acting as consulting architects. The illustrations of this article were prepared by Norman H. McMurrich, B.Arch., of that office.



Suggested Methods of Operation

Routine ADMISSION CHEST X-RAY Program in Hospitals

S. A. Holling, M.D.,
Clinician, and
D. R. Wise,
Technical Assistant,
Division of Tuberculosis Prevention, Dept. of Health, Ontario.

THE Division of Tuberculosis Prevention, Ontario Department of Health, has prepared the following data with a view to assisting hospitals in making a success of a routine admission chest x-ray program.

The decision as to whether special x-ray equipment should be installed in a given hospital should be based on the total number of miniature chest films which might be taken in a given period, rather than on the number of hospital admissions. This service should not be limited to hospital admissions only but should include other phases of the community tuberculosis diagnostic program.

Before inaugurating such a program, hospital authorities should:

(a) Have a clear understanding of the objectives and the necessity of securing a maximum coverage of all patients excepting newborns, infants and small children.

(b) Make a careful study of the problems of operation in order that the work may be done efficiently with the least possible disturbance to hospital routine.

(c) Explain the method of operation to local doctors and those members of the hospital staff directly concerned, as the success of this program is dependent upon their active co-operation.

(d) Make this a routine procedure as part of the service given by the hospital. The results will be far from satisfactory if the decision as to the need for a chest film is left to the discretion of the patient.

Objectives

1. The discovery of unsuspected cases of pulmonary tuberculosis and other significant chest conditions.

2. Protection of the hospital staff against tuberculosis infection.

Groups Available for Examination

(a) Hospital admissions
(b) The hospital staff
(c) Referred chest clinic patients
(d) Hospital out-patients
(e) Tuberculin reactors among special groups and their close contacts, especially in the family
(f) Applicants for employment in industry
(g) Office patients of private physicians, especially pre-natals and diabetics.

It is suggested that the work be limited at first to the hospital staff and to referred chest clinic patients and admissions, the service being gradually expanded to include the other groups as experience is gained.

Equipment

Experience has shown that a complete miniature film x-ray unit rather than a camera attachment for use with the existing hospital x-ray equipment is highly desirable, if the x-ray department is at all active. While under the direction of the x-ray department it should be located in or as near as possible to the admitting office and be operated as part of the admission routine. Whether or not a full time technician is required will depend on the amount of work involved. It is essential that several other members of the staff be trained to operate the unit in order that patients may be x-rayed when the technician in charge is off duty.

The problems involved in securing a maximum coverage will be considerably increased if a miniature film camera attachment is used with the hospital x-ray equipment. In most instances, the x-ray department is not located near the admitting office and is usually busy a considerable part of the day. In such cases, a specific time will probably have to be set aside by the x-ray department for the examination of those patients admitted without chest films. Doubtless the present technical staff

1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19

Date_____ Film No._____

NAME_____ ADDRESS_____

Age_____ Sex_____ PHYSICIAN_____

Miniature Chest Film Service

Ward_____

( ) Admission 1. ( ) Chest Clinic 2. ( ) Special 3._____

Room_____

PROVISIONAL DIAGNOSIS

( ) No significant Pathology

( ) Film unsatisfactory - repeat

TUBERCULOSIS

4. ( ) Suspect
5. ( ) Primary
6. ( ) Minimal
7. ( ) Mod. Advanced
8. ( ) Far Advanced
9. ( ) Probably Active
10. ( ) Activity questionable
11. ( ) Probably Inactive
12. ( ) Pleural effusion
13. ( ) Thickened Pleura

NON TUBERCULOUS abnormalties

14. ( ) Cardiovascular
15. ( ) Pneumonia
16. ( ) Bronchiectasis
17. ( ) New growth
18. ( ) Other (specify)

19. ( ) Further investigation (a) now ( ) (b) chest clinic ( )

( ) Sputum exams. (3 specimens)

Code Numbers at Top of Card represent Diagnoses

would be able to handle this extra work with some secretarial assistance.

Patient Traffic

It is essential that as many patients as possible be given a chest film before admission to the wards. Therefore, a definite admission routine should be established to permit the x-raying of all ambulatory patients immediately after registration. Maternity cases should be referred to the hospital for chest x-ray as soon as possible after pregnancy has been diagnosed. If the x-ray unit is not in close proximity to the admitting office, adequate signs must be displayed indicating its location. A guide might be necessary in certain instances.

The importance of securing a chest film as soon as possible of patients admitted directly to the wards cannot be too strongly stressed. While this is the most difficult phase of operations, nevertheless, the problem can be solved with proper teamwork. A notice stamped on the outside of the chart would notify the nursing staff that such an individual had not been given a chest film on admission.

A control system should be set up whereby contact can be kept with the wards and arrangements made to bring these patients for x-ray as soon as possible. A list of all admissions for the previous 24 hours should be given to the technician each day in order that it may be checked against the list of patients x-rayed. It is suggested that a board, such as that used at the information desk and containing removable slips, be utilized, the name of the individual not yet x-rayed, the ward and the date of admission being written on the slip. This would remain on the board until the x-ray had been taken.

Reports and Filing

Miniature films should be processed and reported within 24 hours if possible. A simplified method of reporting the findings is desirable and the ballot system is suggested, a check being made against the proper provisional diagnosis. This information should be attached to the hospital chart, either in the form of a sticker or a small envelope containing the film. The latter method eliminates the problem of filing miniature films in the x-ray department and permits easy inspection of the film by the attending physician. The films of special survey groups should be forwarded to the physician responsible for the group concerned for filing.

Records

It is advisable that the technician-in-charge be given the responsibility of keeping all records in connection with this program.

A simple efficient system of recording the findings is essential. Several satisfactory methods are now in use.

(a) A card has been designed in the same manner as the report form printed on the film envelope with the addition of small squares along the top. A code number representing a diagnosis is printed in each square. By using different coloured signal tabs the results can be easily ascertained. (See illustration.)

Most hospitals desire to have regular periodic reports of the findings and for this purpose a monthly spread sheet is used. At the end of the year the total may be quickly tabulated for an annual report.

(b) In some instances a triplicate report form is used which is suitable for either the hospital admission program or special group surveys. This permits a copy of the report to be sent to the physician concerned and the individual, if so indicated. The miniature films are placed in separate envelopes, the necessary information being recorded on the outside and then filed.

(c) Where large numbers are being examined, an International Business Machine card enables a comprehensive analysis of the results to be obtained.

(An article dealing with the cost of routine chest x-rays by the same authors will appear in our October issue.—Edit.).

St. Thomas Service Clubs Contribute Equipment

The Service Clubs of St. Thomas have been active this year in response to an appeal from the Memorial Hospital for additional equipment. Last spring the Kiwanis Club presented the hospital with a cheque for $425.00 for the purchase of a new microscope and in June the Lions Club suggested that the hospital be equipped with a specially built refrigeration unit for the establishment of a blood bank. The unit valued at $850.00 was officially presented to the hospital and some twenty members of the Club volunteered donations of blood. The refrigeration unit will accommodate about 80 bottles of whole blood, 500 c.c. each.

In the photograph above, viewing the new unit, are, left to right, D. Doan, past-president of the Lions Club; R. Ray Copeland, superintendent of the hospital; Mayor Bruce Caldwell; and George Ranking, past-president of the Lions Club.

Have You Taken Every Precaution to Protect Your Hospital Against

Fire?

Major C. M. Young,
Office of the Fire Marshal, Fredericton, N.B.

SOME of our hospitals in New Brunswick leave much to be desired in the way of fire prevention practices and fire prevention appliances, although some progress is being made in this regard. It is hoped that in the near future, a member of the Fire Marshal's staff will accompany Dr. Porter, Director of Hospital Services, on an inspection tour of all hospitals in New Brunswick.

In spite of the financial status of most hospitals, and the shortage of labour and materials, it must be realized that safety measures must be taken in these institutions—and very soon. The Fire Marshal's branch does not propose to deal lightly with the question of the removal of fire hazards from hospitals after inspections of these institutions are made.

The percentage of fire causes in hospitals is broken down as follows:

	Per cent
Smoking and Matches	21
Electrical	16
Heating defects	19
Spontaneous ignition	9
Inadequate rubbish disposal	7
Static sparks	4
Open flame devices	4
Flammable liquids	6
During repairs and alterations	4
Miscellaneous	10
	100

These quotations are in respect to material hazards, but it is obvious that in no other type of occupancy is it so necessary to protect life. Some of the steps which may be taken to provide this protection are:

(a) The training of the hospital staff in fire prevention methods, including the method of evacuation in event of fire.

(b) The provision of adequate and proper type of first aid fire fighting equipment.

(c) The provision of proper and adequate fire exits.

(d) The provision of fire stopping facilities in new and existing buildings.

(e) Full appreciation of the toxic effect of burning rags and such related material, or the effect of superheated air upon the lungs of patients.

(f) An appreciation of how quickly a fire spreads, even in a so-called fire-proof building.

The report of the Dominion Fire Commissioner, for 1946, shows the fire record for hospitals, sanatoria, and institutions as:

Eighty-one fires, with a loss of $35,132, with a loss of life of two men and one woman.

Recommendations for the implementation of the fire prevention and protection measures mentioned previously are as follows:

1. The hospital staff to be given instruction in the duties which they will be required to perform on any outbreak of fire.

Fire orders, covering evacuation proceedings, should be formulated and posted conspicuously by the matron or business manager.

Arrangements should be made whereby off-duty personnel may be summoned immediately in an emergency. This may be done through the use of an alarm bell located in living quarters or by other assured means. The same applies in regard to the warning of fire throughout the institution or hospital building. Alarm stations should be installed on all floors, in order that the desk attendant may be advised immediately a fire is discovered and can place a call for assistance with the nearest fire brigade.

2. Where water supplies of assured volume and pressure are available, protection through the installation of a complete sprinkler system is recommended, with hand extinguishers to care for incipient fires. Extinguishers are designed especially for various hazards, and approved types have an attached laboratory label showing its classification. These classifications are "A", "B", or "C". "A" class extinguishers are designed to control fires in ordinary combustibles, such as wood, paper, et cetera, "B" class for fires in oils or greases, and "C" class for electrical fires where a non-conductor of electricity is required.

3. The provision of assured means of exit from all sections of buildings is a definite necessity. These *exits* may take the form of enclosed smoke-proof stairways having a fire resistive rating of a minimum of one hour; outside fire escapes of the stairway type; or enclosed metal chutes for the evacuation of bed patients. The Fire Marshal will be only too glad to advise as to the most efficient type to place on any building.

4. The use of non-combustible material is recommended, by the National Building Code and all Fire Prevention bodies, in the construction of hospital and institutional buildings, together with the provision of fire stopping at each floor level of side walls and partitions, and the elimination, in as far as possible, of flammable exposed surfaces in existing frame structures.

5. Superheated air may be prevented from spreading throughout a building by the installation of automatic metal clad fire doors at each floor level of stairways or other vertical opening, and at intervals of not more than 75 feet in long corridors or at the entrance to wards or wings. This will also have great

(Concluded on page 106)

An address presented at the Maritime Hosp. Assoc. Convention, St. Andrews, in June.

Maj. Young was formerly Fire Marshal of Military District No. 7.

Australian Writer Proposes

Bungalow Village for Aged

Could be Adapted for Convalescents

"WHEN considering schemes for eventide homes, there are numerous problems common to all homes for the aged," states J. Borries, M.V.I.E., of Melbourne, Australia, in an article in *Hospital and Health Management*. "The fundamental principle that must be considered first is how to make the old people feel that they are living in an ideal home, with modern comforts and good companionship." The plan for homes for the aged which is outlined is one that might well be adapted for the care of convalescents. The illustration reproduced here shows the suggested lay-out of small bungalows providing accommodation for 150 active and semi-active old folk, 150 chronic sick, 50 junior and 50 senior girls in a training home for orphans and unwanted girls, together with the necessary residential staff. It has been designed with a view to the possibility of adding further accommodation.

Mr. Borries' plan is to provide mainly four-room bungalows, heated by a central heating service. This type of home would be suitable for married couples, or those willing to pay for two rooms, accommodation consisting of a sitting room, bedroom, bathroom, small pantry, and lavatory.

A second type containing a bed-sitting-room, bathroom, pantry and lavatory, should be made available for either sex, and a third with bed-sitting-room, bathroom, pantry, and lavatory, might accommodate four persons.

The fourth type should be for those needing help in dressing and washing. For each six persons there should be a sitting-room, common lounge, and special lavatory accommodation. There should also be living quarters for the attendant. Most of these people would require tray service and so homes of this type should be near the central kitchen.

All homes should have verandas protected from draughts.

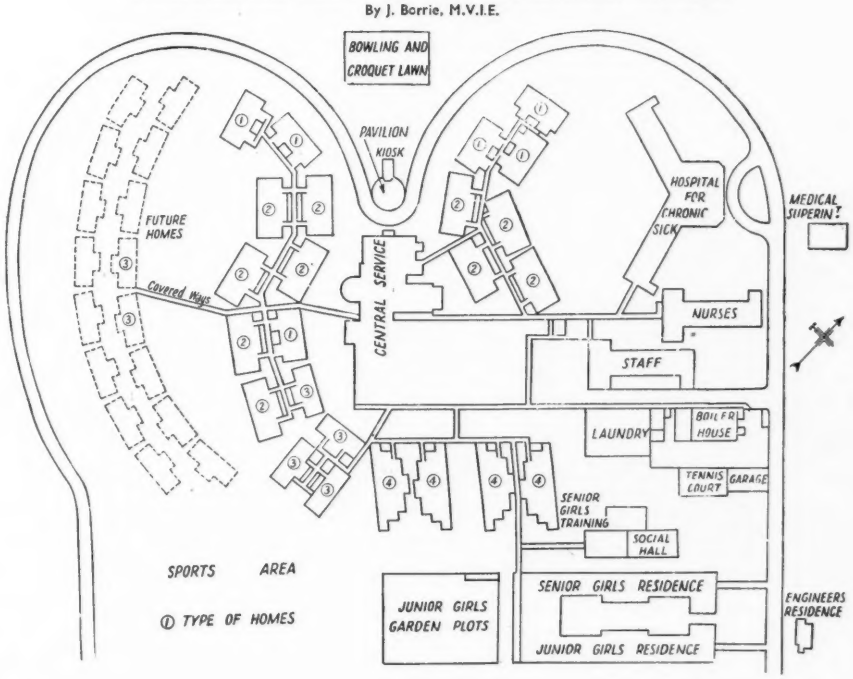
The administrative offices are situated near the central service section. Provision is made for self-service in the dining-room as well as service at tables seating eight persons. Some recreational facilities are included in the plan and there is a sewing room, also a laundry with ironing boards, for the use of inmates. Another important feature is the social and concert hall with comfortable seats and space for wheel chairs.

It is suggested that the hot water system be designed on the hydromix controlled cold water system. In this, tanks are used instead of cylinders, and all cold water passes through the mixer direct to the heating unit, the supply of cold water being controlled to the make-up requirements. This ensures a steady and continuous firing of the boiler or heating unit and reduces fuel consumption.

Mr. Borries' suggested lay-out of bungalow homes is of timely interest and worthy of consideration by those planning new or additional accommodation for convalescent patients.

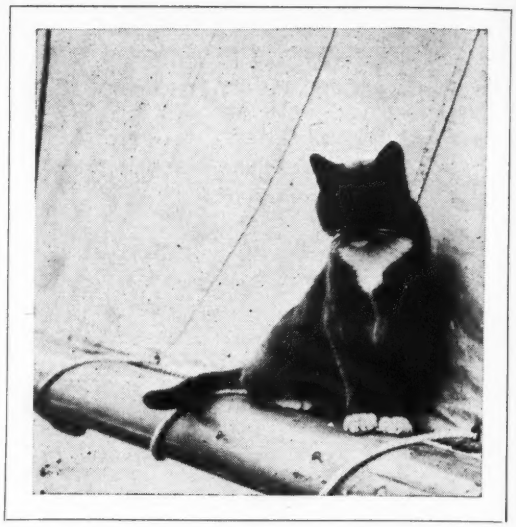
SUGGESTED LAY-OUT OF EVENTIDE HOMES

By J. Borrie, M.V.I.E.



The Hobby Corner

4. E. A. Petrie, M.D.



Prize winning kodachrome at C.M.A. Salon in Winnipeg.

"THERE is nothing — absolutely nothing — half so much worth doing as simply messing about in boats, or with boats . . . In or out of 'em, it doesn't matter." (Kenneth Grahame in *The Wind in the Willows*).

This is the tale of a roentgenologist who at an early age followed the well known advice of A. Edward Newton who said, "Young man get a hobby; preferably get two, one for indoors and one for out. Get a pair of hobby horses that can safely be ridden in opposite directions." (*Amenities of Book Collecting*). That advice may or may not be good. In the present instance the outdoor hobby of boats made a man from "Upper Canada" become a Maritimer, while the indoor hobby (photography) played a part in the making of a roentgenologist with a sustained interest in the technical aspect of his chosen profession. So it may be said that hobbies make the man.

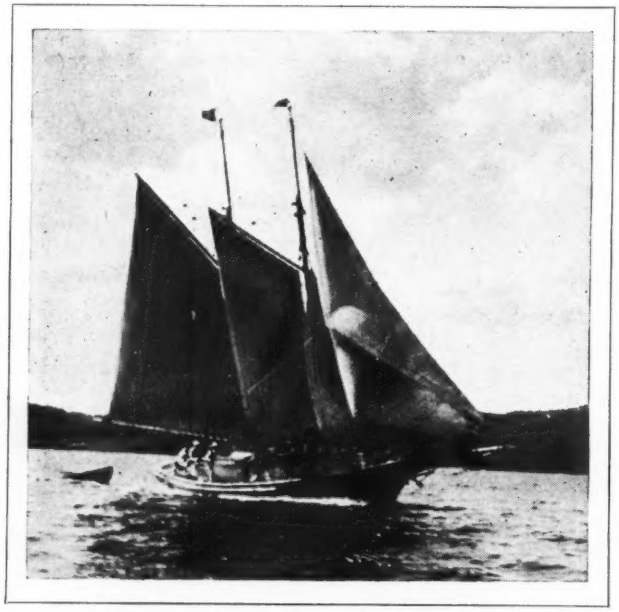
The man in question is Dr. E. A. Petrie, roentgenologist to St. Joseph's Hospital and consulting roentgenologist to the Provincial Hospital, Saint John, N.B. Dr. Petrie was born near Ottawa where he received his preliminary education. Later he studied medicine at McGill University receiving his degree in 1924. Dr. Petrie's hobbies are many and varied and as indicated above these have influenced his life to a considerable degree. His main hobbies are yachting and photography.

As long as he can remember he has been interested in boats. He has owned various kinds, from a very tippy birch bark canoe to his present more sturdy sea-going two masted schooner. While living in Ottawa Dr. Petrie was an active member of the Ottawa Rowing Club. In Saint John he has served as Commodore of the Royal Kennebecasis Yacht Club.

In regard to the other "hobby horse", namely photography, Dr. Petrie's chief interest is perhaps naturally in marine subjects. His work in colour photography has won awards at the Art Exhibits at the meetings of the Canadian Medical Association, in Winnipeg and more recently in Toronto.

Other hobbies include gardening and membership in a literary society, and last but not least, the technical aspect of roentgenology, in which field the doctor's interest has led to his appointment as chairman of the examining board of the Canadian Society of Radiological Technicians. Dr. Petrie wishes it to be stated that golf and bridge are not among his hobbies!

Dr. Petrie and his family live at Rothesay a short distance from Saint John on the shore of the Kennebecasis River where sailing is a major summer activity and where there is ample scope for photography.



This graceful two-masted schooner is one of Dr. Petrie's "hobby horses".

Administration by Nurses of Intramuscular and Intravenous Therapy

R. A. Seymour, M.D.,
Assistant Director, Medical,
Vancouver General Hospital,
Vancouver, B.C.

ADVANCES and changes in treatment and in medical care of patients during recent years have necessitated certain modifications in the method of giving such treatment. Particularly is this noticeable in intramuscular and intravenous therapy, and this report deals more specifically with intravenous saline and blood transfusion therapy and penicillin therapy.

Hospitals must devise ways and means of keeping pace with this advancement and controlling laws or regulations must be adjusted accordingly.

The practice of medicine as it is today does not permit the constant or repeated personal attendance of physicians that modern therapy might demand. Other personnel must then be trained and permitted to give this therapy which requires so much time.

In the past, hospitals with intern service have been able to meet the demand with interns, but now this is being found to be increasingly impractical. Further it is found that hospitals without interns have had to meet this demand through the nursing service.

Wartime conditions accentuated this problem and therefore hastened changes in hospital practice.

In hospitals all across Canada, intramuscular and intravenous therapy is now being given by the nursing service.

Legal Position: What has been done to clarify it?

In June, 1941, a joint conference of representatives of the Canadian Nurses' Association and Canadian Hospital Council resolved that it reaffirms the principle already endorsed by the Canadian Hospital Council and by the Nursing Education Committee of the Canadian Nurses' Association, to wit, that in those hospitals unable to obtain adequate intern service it should be considered sound procedure for hospitals to permit the following to be performed by nurses, provided such be done by one or more graduate registered nurses on the hospital staff carefully selected and trained for this work:

Blood pressure readings
Subcutaneous injections
Intravenous injections of saline and glucose solutions and such other medications or diagnostic fluids as the medical staff may authorize
Taking of Wassermans
Removal of sutures
Intramuscular injection of substances specifically authorized by the medical staff
Recording of histories (with the exception of physical examination)
Progress notes as dictated by the physician in charge
Such other clinical procedures as may be recommended by the medical staff and approved by the director of nursing and the board of trustees.

It was further resolved that before instituting any part or all of the above outlined arrangement such be approved by the organized medical staff, by the director of nursing and the governing body of the hospital.

The above resolution was presented to the Executive Committee of the Canadian Medical Association and this resolution was tabled.

Correspondence from the General Secretary-Treasurer of the Canadian Nurses' Association and the Executive Secretary of the Canadian Hospital Council is on my file to this effect.

The practice of nursing has never been fully defined in any of the Nurse Registration Acts in Canada.

The Canadian Nurses' Association know of no record of any legal judgments handed down in courts regarding such practice.

The Canadian Nurses' Association do not know of any nursing text book which gives any of the above listed practices as nursing procedures.

In reference to text books, the Executive Secretary of the Canadian Hospital Council, Dr. Harvey Agnew, states that formal approval by medical staffs of various procedures by qualified nurses would carry more weight because text books in many cases are obsolete by the time they are published.

The National League of Nursing Education, New York, replied to my inquiry in regard to text books and legal judgments and referred me to Milton J. Lesnik, Counsellor at law, author of a book with the title "Legal Aspects of Nursing". The points of his reply are as follows:

(a) He knows of no legal judgments on this question.

(b) He is of the opinion that my viewpoint and conclusions are correct and substantiates them by the following:

1. As of the date hereof, 11 states and one territory have attempted to define legally the practice of nursing. All of these statutes, either directly or by implication, contain a reference to the fact that the practice of nursing includes "a carrying out of treatments and medications as prescribed by a licensed physician".

2. This statutory provision has been construed to mean that one of the dependent functions of nursing requiring the fulfilment of a condition precedent, is the right of nurses to engage in the practice of medical acts, but subject to:

(a) Prior order on the part of a duly licensed physician, given with
(b) Specific directions, and
(c) Performed by a nurse who has full understanding of the execution of that order and the cause and effect thereof.

3. As further evidence of the nurse's right to perform certain medical acts under the conditions as outlined above, the various laws defining and limiting the practice of medicine,

A study was made and the report prepared by Dr. Seymour at the request of the Directors of the British Columbia Hospitals Association.

generally include as an exemption the practice by nurses under specific conditions; for example, the laws of the State of New Jersey, Revised Statutes of New Jersey, 1937, Section 45; 9-21, provides as follows:

"The prohibitory provisions of this chapter, concerning persons and the practice of medicine shall not apply to the following:

" . . . par. K. A professional nurse . . . while operating each particular case, under the specific direction of a regularly licensed physician or surgeon . . . "

4. The inclusion of legal definitions of nursing in the laws of the various states, as well as the provisions of exemption in the laws defining the practice of medicine, permit the practice of various acts, such as administration of anaesthetics, suturing of wounds, giving of intramuscular treatments and intravenous therapy, et cetera, under the following specified conditions and for the reasons as stated:

(a) The definitions of nursing provide that no nurse is to fulfill any order or execute any procedure or technique without a full understanding of cause and effect. This places the responsibility for executing an order severely upon the nurse. Absence or lack of special and qualified training would prohibit the execution of any order involving the execution of a medical act.

(b) No such order can be executed unless given by a regularly licensed physician.

(c) The term "specific direction" as used in the medical act, is construed to place the responsibility upon the nurse to understand "the cause and effect of such an order".

5. In states where nursing is not defined nor does the medical act provide for certain exemptions concerning the practice of activities herein discussed, by nurses, the same conclusion is obtained because the authority to pursue these practices by nurses *is based upon custom which has the effect of an implied law.*

This matter is discussed on pages 153-156 of the text *Legal Aspects of Nursing.*

6. Dr. Seymour is correct in stating that, in the first instance, only nurses who are specially trained should be permitted to perform these techniques. However, the question of liability of a hospital is not determined solely by proving special qualifications. Therefore, this conclusion is only partially correct.

It is conclusive that if a hospital would permit a nurse who is not specially trained to perform such techniques, the question of negligence would be clear.

However, as in all situations, a hospital is responsible for the acts of negligence of its employees, incurred during the course of their employment, unless they are exempt under the rules of immunizing charitable institutions. The discussion of this doctrine is made in full, in the text, at pages 163-170.

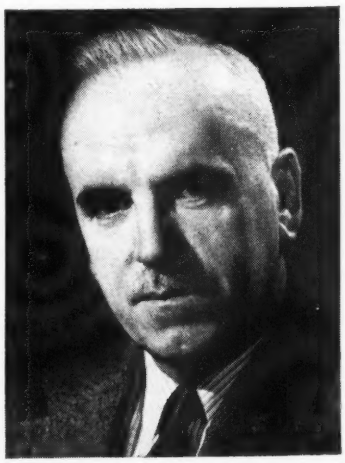
7. There is a split of authority in the decisions in the United States whether the physician under whose specific direction and order the nurse is performing these activities is jointly responsible for her acts of negligence, where the nurse is not the employee of the physician. (Of course, where the nurse is the employee of the physician, he is responsible.) Where the nurse is an independent contractor of the employee of another, many states hold the physician jointly responsible for the reasons discussed in the text at pages 103-107. A recent decision in the case of Ybarra v Spangard, et al., 154 Pacific Reporter 2nd 687, Supreme Court California, December 27th, 1944, rehearing denied January 25th, 1945, has indicated that physicians would be jointly liable.

Conclusions

A hospital employing a nurse to give or permitting a nurse to give intramuscular or intravenous therapy is within the law providing:

1. That the nurse is a "Registered Nurse" that is within the meaning of the "Registered Nurses Act".
2. That she is qualified by special training and instruction.
3. That the order for such therapy is given by a duly licensed physician.
4. That she has full understanding of the execution of that order and the cause and effect thereof.
5. That such procedure has been approved:
   (a) By the director of nursing.
   (b) By the organized medical staff.
   (c) By the governing body of the hospital.
6. That the attending physician ordering this therapy is aware that it will be given by a nurse qualified as above.

James Gibbard to Head Laboratory of Hygiene



James Gibbard of Highland Park has been appointed by the Civil Service Commission to head the Laboratory of Hygiene in the Department of National Health and Welfare, Ottawa.

A member of the federal civil service for 20 years, Mr. Gibbard has served as senior bacteriologist in the Laboratory of Hygiene. In January, 1946, he was appointed assistant chief of the Laboratory. At present, he is chairman of the Nepean Board of Health and chairman of the new Carleton Health Unit.

A graduate of the University of Toronto, Mr. Gibbard spent two years as an assistant in the bacteriology department of the University of Massachusetts. He was then awarded a fellowship for two years in the department of hygiene and bacteriology of the University of Chicago from which he received his master's degree. He is the author of about 35 publications in various scientific fields.

Mr. Gibbard is a fellow of the American Public Health Association and is also a member of the American Society of Immunologists, the Canadian Public Health Association, and associate fellow of the Academy of Medicine, Ottawa.

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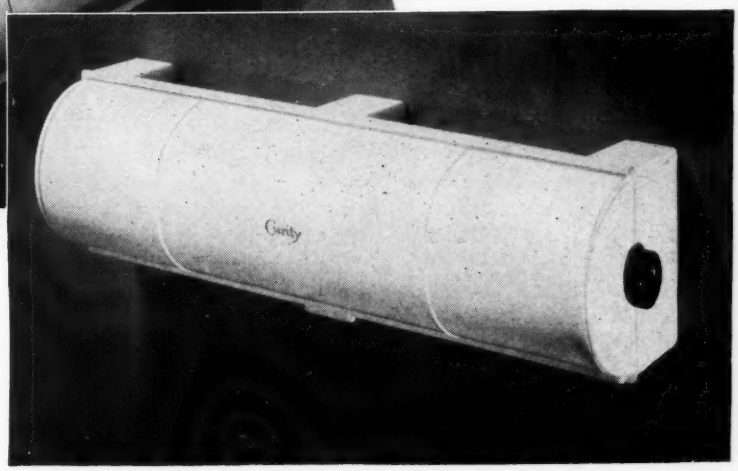

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Provincial and Federal Representatives Discuss Federal Grants

Back row (left to right): Dr. H. A. Ansley, Ottawa; Dr. Ernest Couture, Ottawa; Donald Clark, Ottawa; J. Howes, Ottawa; Dr. G. E. Wride, Regina; Dr. F. D. Mott, Regina; Dr. J. M. Hershey, Victoria; J. Gibbard, Ottawa; Dr. G. F. Davidson, Ottawa; C. W. Gilchrist, Ottawa; J. T. Marshall, Ottawa; T. J. Giles, Ottawa; J. W. Willard, Ottawa; R. E. Curran, Ottawa; G. S. Tattle, Toronto; Dr. D. F. W. Porter, Fredericton; Dr. Harold Shaw, Charlottetown; Dr. K. G. Gray, Toronto;

Front row (left to right): Dr. P. S. Campbell, Halifax; Dr. M. R. Bow, Edmonton; Dr. R. D. Defries, Toronto; Dr. G. F. Amyot, Victoria; Dr. B. D. B. Layton, Ottawa; Dr. C. F. W. Hames, Regina; Hon. Paul Martin; Dr. G. D. W. Cameron, Ottawa (chairman); Hon. George H. Dunbar, Toronto; Dr. J. T. Phair, Toronto; Dr. J. A. Melanson, Fredericton; Dr. B. C. Keeping, Charlottetown; Dr. F. W. Jackson, Winnipeg; C. E. Fillmore, Clandeboye, Man.; Dr. C. R. Donovan, Winnipeg.

Further Details Available Respecting Federal Health Grants

EXACT amounts available to each province out of the $30,000,000 national health grants voted by Parliament have been announced by the Hon. Paul Martin, Minister of National Health and Welfare.

Allotted mainly on the basis of estimated 1947 provincial populations, the amounts are: Ontario, $9,667,979; Quebec, $8,985,035; British Columbia, $2,529,153; Saskatchewan, $2,001,742; Alberta, $1,968,738; Manitoba, $1,805,965; Nova Scotia, $1,541,779; New Brunswick, $1,226,052, and Prince Edward Island, $293,857.

Only one grant — $100,000 for public health research — is not being allocated on a provincial or population basis. All grants, including the research grant for 1948-49 total $30,120,300.

The largest single type of grant is $13,000,000 for **hospital construction.** Divided on a population basis, it makes available a ceiling amount of $4,336,439 to Ontario; $3,842,650 to Quebec; $1,080,745 to British Columbia; $871,636 to Saskatchewan; $850,932 to Alberta; $769,151 to Manitoba; $642,857 to Nova Scotia; $508,282 to New Brunswick and $97,308 to Prince Edward Island.

These sums are available on condition that the province concerned at least matches the Dominion's contribution.

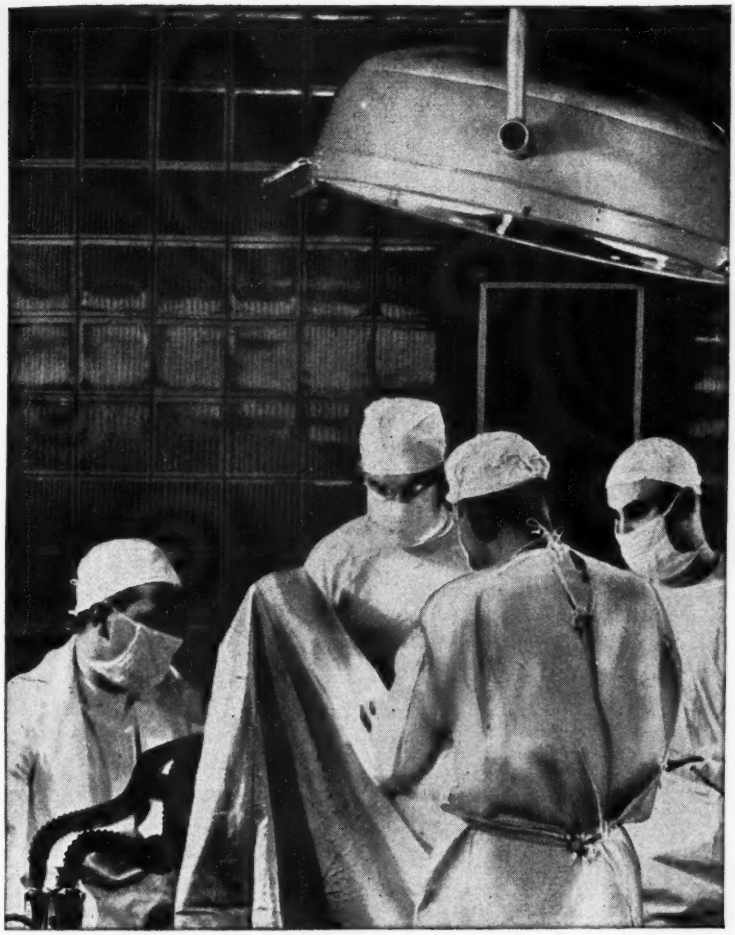
Subject to the overall ceiling based on population, the money will be divided among specific building projects on the basis of $1,000 for each active treatment bed or bed equivalent and $1,500 for each chronic or convalescent bed. These grants apply to new hospitals or nursing units or additions to existing buildings commenced on or after April 1st, 1948, subject to a proviso that in no instance will the amount paid from federal funds exceed one-third of the cost of construction.

In the instances of new buildings or additions under construction on April 1st, 1948, the amount to be paid is based on the $1,000-$1,500 per bed formula in relation to the amount of construction to be completed after March 31st, 1948, and to the total cost of construction, or an amount up to one-third of the total cost of the portion of the construction still to be completed after March 31st, 1948. Whichever formula yields the lesser amount is to apply. At the end of five years the hospital construction grants are to be reviewed.

Initial Studies. Basic to the whole health program is a grant of $625,000 to assist the provinces in setting up the machinery to ensure the most effective use of the health grants, to plan the extension of hospital accommodation and the proper organization of hospital and medical care insurance. The grant is being divided on the basis of $5,000 to each province and the remainder on the basis of population with a proviso that no province will get less than $15,000. While this is not a recurring grant any amounts not spent in the current fiscal year may be made available for use in succeeding years.

The second largest type of grant is $4,000,000 for **mental health** which is divided on the basis of a $25,000 flat grant to each province and the balance according to population. Provincial directors of mental health have already met with the federal department and with university representatives to map out programs of action, with emphasis on training of professional personnel to staff new hospitals

THE PROPER ANAESTHETIC



Aside from the great skill acquired through many years of clinical experience, the physician or surgeon must necessarily depend upon the armamentarium at his command.

Not the least important consideration is the choice of the proper anaesthetic, which not only must be pure and dependably stable under all circumstances, but also must exhibit uniform potency at all times.

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and clinics. The mental health grant is to rise over a period of years to a total of $7,000,000 annually.

The sum of $3,500,000 has been earmarked for **cancer control.** Allotted on the basis of population, it provides ceiling amounts of $1,167,503 for Ontario, $1,034,560 for Quebec, $290,970 for British Columbia, $234,671 for Saskatchewan, $229,097 for Alberta, $207,079 for Manitoba, $173,077 for Nova Scotia, $136,845 for New Brunswick, and $26,198 for Prince Edward Island. Like the hospital construction grants, these funds are available for approved programs of cancer control provided the province matches the federal contribution.

The **tuberculosis** control grant totalling $3,000,000 this year and rising over a period of years to $4,000,000 is divided on the basis of a $25,000 flat amount to each province, with the balance divided 50 per cent on the basis of population and 50 per cent according to the average number of deaths (including Indians) from tuberculosis in each province over the five-year period from 1942 to 1946 inclusive.

Half a million dollars each has been allocated for programs to aid **crippled children** and to further **professional training** of public health personnel. Both grants have been divided on the basis of a $4,000 flat amount to each province and the remainder according to population. (It has been stated that one half of the grant for professional training, i.e., $250,000 per annum, is to be earmarked for the training of hospital personnel.—Ed.)

To strengthen **general public health services,** such as the control of communicable diseases and the development of child and maternal health programs, a sum of $4,395,000 has been allotted on the basis of 35 cents per capita of population. This amount will rise by five cents per capita each year to a maximum of 50 cents annually. On the present basis British Columbia will receive $365,400; the Prairie Provinces, $842,450; Ontario, $1,466,150; Quebec, $1,299,200; and the Maritime Provinces, $422,100.

Under arrangements first made during the war, the federal government has been spending $225,000 annually on the control of **venereal diseases.** Of this amount $50,000 was for purchase of drugs for treatment of these diseases. Under the new health program, the allocation for venereal disease control has been increased to $500,000.

The $100,000 grant for **public health** research is not divided either on a provincial or a population basis. Each project must be submitted with full details to the Dominion Council of Health which will recommend to the minister of National Health and Welfare whether or not the project should be accepted.

Detailed provision is made in the orders-in-council for consultation between the provinces and the federal government on proposed developments, the exchange of reports and procedure by which payments are to be made.

Catholic Conferences Hold Record Meeting at Quebec

THE largest hospital convention ever held in Canada (except, of course, the A.H.A. meetings in '31 and '39) took place in Quebec City in August when the Montreal and Quebec Conferences of the Catholic Hospital Association held their three-day Biennial Congress. Well over one thousand sisters, clergy, physicians and others were registered.

This congress immediately followed a very enthusiastic two weeks' Institute which evoked much favourable comment from the large number in attendance.

Commencing with an opening mass by Abbé Victorin Germain, director of the Quebec Conference, and a spiritual conference led by R. P. Philéas Garneau, O.M.I., the program was well varied. Members of the medical faculty at Laval contributed papers and took an active part in the round tables. Dr. J. C. Miller, professor of psychiatry, spoke on modern orientation; Dr. Georges Montel on the psychology of the sick; and Dr. Roméo Blanchet, secretary of the faculty, on psychosomatic medicine. R. P. Henri Samson, S.J., spoke on psychiatry and Abbé Germain on professional secrecy and social service. Brief reports on the work of the two Conferences were given by the two presidents, Mother Sainte-Jeanne-de-Chantal, O.S.A., of Quebec and Sister Paul-du-Sacré-Coeur, F.C.S.P., of Montreal, and by two secretaries, Sister Madeleine Durand, F.C.S.P., of Montreal and Mother Saint-Adolphe, O.S.A. of Quebec.

Out of courtesy to several guest speakers, the second day's program was conducted in English. The speakers were Dr. M. T. MacEachern who gave addresses on the new point scoring system of the A.C.S., medical records, the functions of the medical director and medical staff organization; Dean Conley of Chicago who discussed the work of the American College of Hospital Administrators and the training of administrators; and Dr. Harvey Agnew who spoke on Codes of Ethics and gave an illustrated talk on the evolution of hospitals. Hospital films were shown in the evening. Although it was apparent that most of the sisters understood English very well indeed, Father Bertrand interpolated helpful interpretations on occasion.

A feature of the Institute was a requirement that the registrants themselves prepare and present a short discussion on some one of the topics under consideration. This procedure had been followed at the Institute in Montreal some weeks earlier and had aroused a great deal of interest. No speech—no certificate!

Much credit is due to the arrangements committee for the way everything was handled. Particular praise is due Father Bertrand for his organizing ability, his fine conduct of the sessions and his direction of the round table discussions. The exhibits were numerous and well arranged, and suppliers would seem to have done a thriving business.

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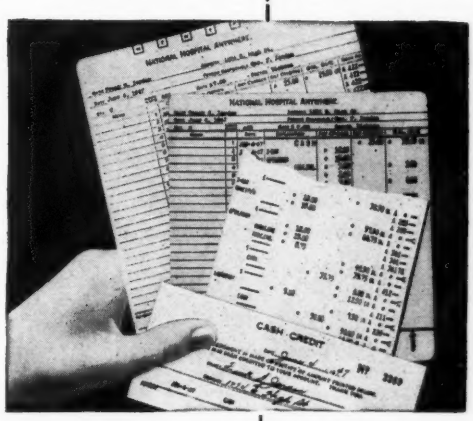

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An economical method of relieving bed shortage

THE Montefiore Hospital of New York City, now in the second year of experience in extending its facilities and care to patients in their homes through its Home Care program, reports that the plan is medically, socially and financially valid; that adequate care at home can be provided by the hospital without causing too great a burden on the family; that the cost is reasonable; and that hospital beds can be saved for the more needy cases.

Montefiore Hospital's special field is in long-term illnesses requiring hospitalization, with the exception of contagious, mental or custodial types. Due to the fact that the greater portion of funds during the Home Care experiment ($30,000) came from the New York Cancer Committee, the majority of patients handled were suffering from neoplastic diseases. However, with additional funds supplied by the Greater New York Fund, and small private contributions, care was extended to patients with heart disease, peripheral vascular disease, neurological disturbances, severe diabetes, tuberculosis, arthritis, ulcerative colitis, and other diseases which fall into the category of long-term illness.

The program for the first year was originally planned to provide for a census of about thirty to thirty-five patients for a year at a total cost of $35,000. The average census at the end of the year proved to be thirty-one, increasing from twenty during the first six months to 40.5 during the last six months. Patient load was carefully restricted and the experimental period was used not only to provide care but to solve the problems which existed at the beginning. At the end of the year, the Department of Home Care was in the unique position of having a surplus.

Organization and Services

The Department of Home Care is an administrative department directly responsible to the office of the director. The sub-divisions of medicine, social service and nursing care, are responsible to the Home Care Executive, Dr. Martin Cherkasky, who divides his time between administrative duties and the care of patients. Dr. Daniel Laszlo, head of the Division of Neoplastic Diseases, provides part-time consultation services. Additional staff were added during the latter part of the year, and the various specialties in the hospital were utilized many times.

Nursing services were carried out, under contract, by the Visiting Nurse Service of New York. The Visiting Nurse made as many calls as necessary on home patients up to a maximum of once a day. Two part-time social service workers and a part-time supervisor were employed. The full-time secretary also served as receptionist. Housekeeping services were procured, as required, from the New York State Employment Service, or from the neighbours and friends of the patients.

The hospital furnished all necessary equipment such as hospital beds, foam mattresses, trapezes, wheel chairs, rubber rings, bed pans, et cetera, also syringes and needles, dressings and bandages, special types of crutches, orthopaedic braces and all medication required.

Transportation for patients to and from the hospital was taken care of by means of ambulance or taxi.

Of the total of 121 patients under Home Care, 40 were re-admitted to hospital, 13 died at home, 19 died after re-transfer to hospital, 9 were discharged, and 14 were discharged to the out-patient department.

A total of 2,007 medical calls were made and 11,146 days of care provided. There were 1,150 visits by nurses.

Expenditures

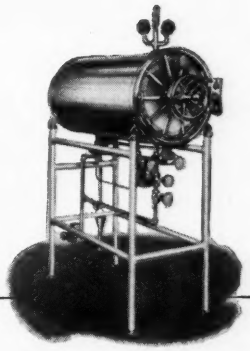
Of the total fund of $39,573.00, expenditures amounted to $24,804.05, leaving a balance of $14,768.95. The expenditure figure represents the cost for the care of 121 patients during the year. The over-all cost per patient day was $2.25. It is interesting to note that, at $12.00 per day, (approximately the hospital cost), the expense, if kept in hospital, would have been $133,752.00. (This would seem to be a book calculation and would not necessarily be the added cost.—*Edit.*)

There was a continued decline in the daily cost per patient, the cost during the month of December, with an average census of 51 patients, being under $2.00. Although hospital costs continued to rise, Home Care costs did not rise proportion-

(Concluded on page 78)

Condensed from the first annual report of the Department of Home Care, Montefiore Hospital, N.Y., of which Dr. E. M. Bluestone is the director.

Scanlan-Morris A420s Pressure Dressing Autoclave recessed in wall.



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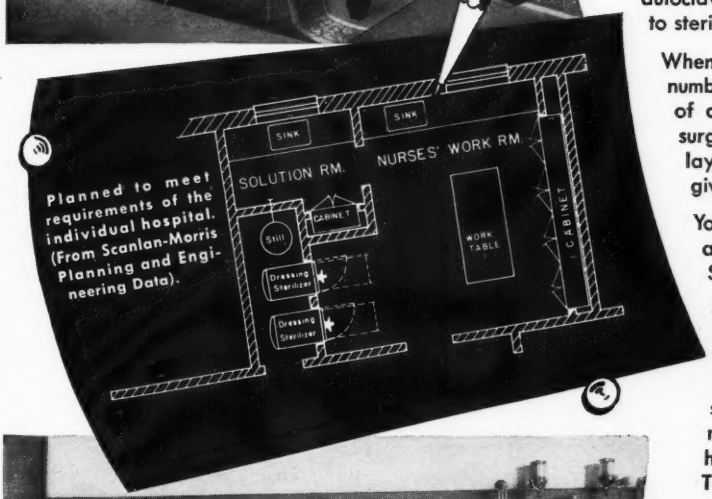
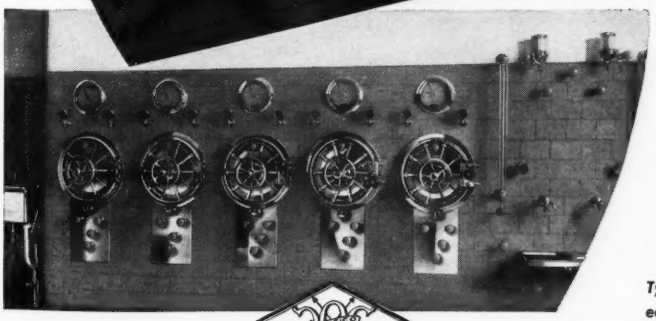


Planned to meet requirements of the individual hospital. (From Scanlan-Morris Planning and Engineering Data).



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Present Status of Streptomycin *in Tuberculosis Treatment*

R. F. Farquharson, M.B.,
Professor of Medicine,
University of Toronto.

THE use of streptomycin in the treatment of tuberculosis is influenced by the factors which are important in the regulation of chemotherapy in general. It is bacteriostatic only; it suppresses but does not eradicate the tuberculous disease; after initial improvement under the drug the disease relapses unless the body is able to handle the residual infection. It is most effective in acute soft tissue lesions and has little influence on low-grade, chronic disease in which the tubercle bacillus may lie dormant or on disease in relatively avascular tissue (chronic fibroid or caseating disease with or without cavities, bone lesions, et cetera). Most strains of tubercle bacilli isolated from human sources are quite sensitive to small concentrations of streptomycin (1.0 microgram per c.c. or less), rarely requiring more than 3.0 micrograms per c.c.; unfortunately, tubercle bacilli surviving in lesions of patients under treatment are soon found to be highly resistant to its action. Accordingly, definite effects are noted chiefly in the first month or two of treatment, and more prolonged therapy is usually of little or no value.

It is the present tendency to give smaller amounts than were formerly used, and recent American experience seems to indicate that the intramuscular administration of 1.0 gram per day in two doses at twelve hour intervals may be quite as effective as the larger dosage previously employed (1.8 to 3.0 grams per day in multiple injections). Dr. P. H. Greey has shown that injections of 0.5 gram at twelve hour intervals will maintain effective blood levels.

The following statement about results is based largely on a review of the American literature and on less extensive but similar experience in our own D.V.A. and civilian hospitals.

Courtesy of the Ontario Tuberculosis Association.

Tuberculous Meningitis — Early dramatic improvement (dosage 3.0 grams per day intramuscularly, 100 to 200 milligrams intrathecally) is common but fatal relapses occur after intervals varying from a few weeks to several months. It is doubtful if streptomycin therapy is worth while.

Military Tuberculosis without Meningitis—Great improvement may occur and, although serious relapse is frequent, it is probable that the mortality rate will be lowered by streptomycin therapy.

Laryngeal and Tracheobronchial Ulcerative Lesions — The use of streptomycin is indicated for symptomatic relief brought about by healing of the ulcers, although the chronic pulmonary disease usually associated is seldom materially affected.

Pulmonary Tuberculosis—Streptomycin therapy has little effect on chronic fibroid and caseating lesions with or without cavitation, and should not be used in these cases. In acute exudative disease such as tuberculous bronchopneumonia it often brings about remarkable temporary improvement and, although relapse usually occurs, the temporary effect may render other proven methods of treatment more effective. The ultimate value of the drug will be determined by further experience.

Tuberculous Empyema — Streptomycin therapy has proved to be of little value.

Tuberculous sinuses from soft tissue lesions may heal, at least temporarily, under streptomycin therapy; relapse indicates the need for continuation of other forms of treatment.

It is too early to make any statement about results of streptomycin therapy in lesions of the gastrointestinal and genitourinary tracts, pericardium, bones and joints or skin. It seems reasonable to use it as a prophylactic agent when tuberculous lesions have been incised or when healthy tissues have been contaminated with tuberculous material during surgical operations.

Streptomycin should not be used in treatment of any type of tuberculous disease likely to respond to ordinary measures because the results to be expected do not justify the risks of toxic reactions.

Toxic Manifestations—Drug fever, urticarial skin eruptions and albuminuria may occur but are usually not severe and often disappear while treatment is being continued. Troublesome dizziness due to vestibular damage is common among tuberculous patients receiving long-continued treatment with larger dosage; in most instances there is later substantial but not always complete recovery. Loss of hearing is less common but more serious, for it may go on to complete deafness; it occurs chiefly when more than 3.0 grams per day are used. Any loss of hearing in a patient receiving streptomycin is an indication to stop the drug. Agranulocytosis occurs but is very rare.

On the whole streptomycin has been a disappointing drug, for the results of therapy in tuberculosis fall far short of the early hopes and expectations. It has, however, a limited usefulness now, and furthermore the demonstration that tuberculous lesions may be strikingly influenced by a chemotherapeutic agent gives a sound basis for the hope that other persistently effective remedies may be discovered.

Little Hospitals

At first the people were terribly frightened at the idea of coming to a hospital. There is one advantage in planting little hospitals out in rural districts; it gets the people used to the idea, and after all the little hospial is not so awe-inspiring as the big one. It is most unfortunate that people who dread hospitals will, after all, come to the hospital when they are dying; they die there, and of course their friends are more afraid of the hospital than ever. — *"A Friendly Adventure" — Dr. A. J. Hunter.*

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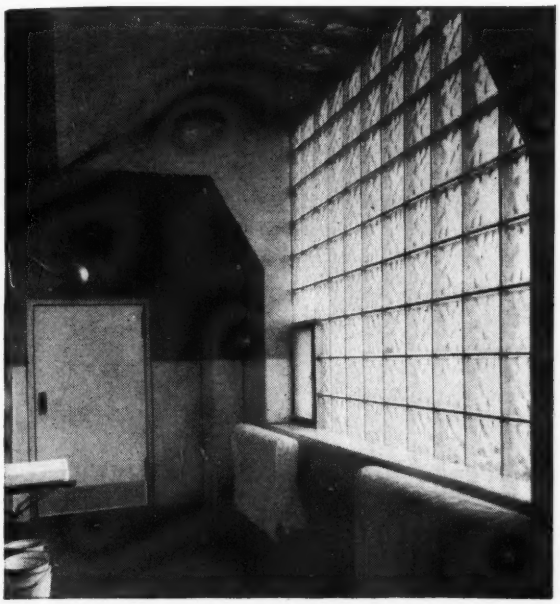

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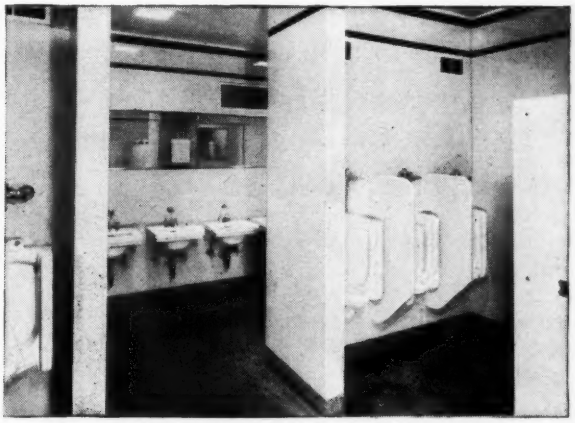

Used in washrooms, toilet stalls, laboratories, operating rooms, Carrara structural glass means permanent, easy-to-maintain sanitation. Carrara is non-absorbent and impervious. Will not give off odours or discolour.

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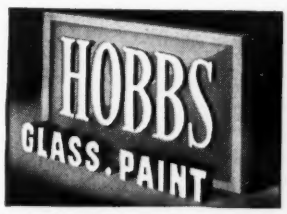

Vancouver Cares for the CHRONICALLY ILL *in their* Own or Foster Homes

(The following outline of the arrangement in Vancouver has been furnished by Miss O. V. Cotsworth, Reg. N., Director, Social Service Department, Vancouver General Hospital, through the courtesy of Dr. R. A. Seymour, the Assistant Director, Medical.)

AT the present time the City Social Service Department is operating thirty-six boarding homes for chronic patients and elderly people who are able to help themselves and do not require bed care. These boarding homes are for those unable to pay for this care and who are eligible for city social assistance as medical indigents. Included are patients receiving the old age pension, city social assistance, war veterans allowance, and some in the low income group.

The boarding homes are under the direct supervision of the City Social Service Department (Medical Section) and include two special boarding homes for tuberculosis patients (convalescent patients with negative sputum). The homes are licensed by the City of Vancouver and must meet building requirements, fire regulations, et cetera. They are also supervised by the Provincial Department of Health and Welfare (B.C. Welfare Institution Licensing Act). At the present time the City Social Service Department has no doctor on the staff, supervision being carried out by the nurses in the medical department, acting under the City Social Service and the Metropolitan Health staffs.

Under the present system the patient may attend his own doctor or the outpatients' department, Vancouver General Hospital. Payment for the doctors' services is made through a combined fund administered by the Vancouver Medical Association. (This does not include the O.P.D. medical staff, except for dental treatment.) Medicine and medical necessities are provided free by the City Social Service Department, upon a written medical order. These arrangements have been in effect since 1937. Referral for placement in these homes is done through the Hospital Social Service, Vancouver General Hospital, and for outside patients by the attending doctor direct to the City Social Service, Medical Department.

For patients not eligible under the City Social Service, the hospital, through the Hospital Social Service, obtains private accommodation in licensed boarding or nursing homes, the patients or relatives taking the responsibility for the financial arrangements. There are now several homes available, which have been opened by national or religious groups: i.e., Jewish, Swedish, Icelandic, Norwegian; also Danish national homes, Salvation Army, Roman Catholic, Mennonite religious homes, including new ones being planned by the Anglican and United Church.

Nursing Homes

In 1937 the City Social Service Department, under its medical department, arranged nursing home care for chronic and convalescent cases in selected private hospitals. Working in conjunction with the Vancouver General Hospital Social Service Department, this program continued quite smoothly until July 1st, 1942. At this time the City Social Service Department decided that it was not in a position to give adequate medical supervision and did not deem it proper to continue with the previous program. This meant that accommodation was not available except for a limited number in the Provincial Infirmary, and the Vancouver General Hospital was left with an increasing number of chronic and incurable patients in its care.

Since January, 1943, the City of Vancouver (Social Service Department) has, however, accepted financial responsibility for chronic bed patients in Heather Street Annex, Vancouver General Hospital. Admission to Heather Street Annex is made only on permission from City Social Service, Medical Section. Medical supervision is carried out by the hospital; social service supervision by City Social Service and Vancouver General Hospital combined.

In January, 1948, the City of Vancouver accepted financial responsibility also for all patients eligible for chronic care admitted to Glen and Grandview Hospitals, at the rate of $3.00 a day. Medical, dietetic, and social service supervision is still given by the Vancouver General Hospital. Financial responsibility is divided between the Province and the City (80-20).

In addition to the above accommodation, due to acute shortage of chronic beds, the City of Vancouver is also utilizing private nursing home accommodation, if available and necessary. Some fifty patients are occupying such beds at the present time.

Care of Patients at Home

Boarding home rates are not paid to families who care for the patient in their own home, but the usual Social Assistance rates, plus necessary medicines, medical appliances, or medical care, is provided. Patients may or may not attend Vancouver General Hospital outpatients' department, depending on their condition. Transportation is provided to and from the clinic, if necessary.

Patients in the low income group, but not eligible for Social Assistance, may attend the outpatient's department and receive medical care and medicine through that department. If necessary, nursing care at home by the Victorian Order of Nurses can be arranged.

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With the Hospitals in Britain

By "LONDONER"

C. E. A. Bedwell

Dear Mr. Editor:

Bristol is in several respects a particularly interesting city in connection with the operation of the new national health service act. One of the problems is to secure the co-operation of local authorities and voluntary organizations. Bristol provided the earliest example in the United Kingdom. Under the Poor Law Act of Elizabeth it was intended that the local authorities make provision for the old people, but it did not include any special accommodation for those who were sick. In 1695 Bristol remedied this defect by a special act of Parliament under which they were authorized to erect a hospital. The Corporation built St. Peter's Hospital to be supported from the rates.

But that was not the sole source of its revenue. Many private citizens gave large donations. Among them was Dr. Edward Tyson whose life's record has formed the subject of an admirable monograph. Another doctor who contributed to this undertaking was Dr. Thomas Dover who gave his services to the Corporation's hospital, just in the same way as many others have done to voluntary hospitals. The hospital was a beautiful old timbered house which, in recent years, was the office of the Public Assistance Committee, thus retaining its original association with the welfare of the aged and infirm. It was destroyed as part of the terrible damage inflicted by the Germans in the Second World War.

The modern counterpart of this happy alliance between the Corporation and voluntary service is provided in the arrangement made in connection with home nursing. Under the new Act the local authorities may themselves carry out their duties or delegate them to any voluntary body existing for the purpose. The City Council have decided and the Ministry of Health have approved that the work shall be continued, as in the past, by the Bristol District Nursing

Co-operation of Voluntary and Municipal Agencies

Association, except that the City Council will be responsible for the cost. Owing to the fact that the City Council is required to provide an adequate service, night and day, for a population of 440,000 in an area of thirty square miles, some developments will be necessary. It is estimated that this will need nearly one hundred nurses. In order to maintain the standard of work, all of them will be required to have the special training for district work of the Queen's Institute for District Training, in addition to their qualification as state registered nurses. These arrangements will require some extension of the existing accommodation. The over-riding factor which determines the future of all these proposals is to obtain an adequate supply of nurses; that is the "headache", in the language of today, for everyone connected with the health services.

Professor Parry, who is Medical Officer of Health of the City and President of the District Nursing Association, happily provides the connecting link which has facilitated this combined operation. A little incident which occurred as I made my way to an interview illustrates the position which he occupies in the City. I asked my neighbour on the bus to tell me when I reached the stop nearest to the Public Health Department. His observation to ascertain my exact requirement was simply "Parry?" The substitution of a bus service for trams has an important bearing upon the provision and location of health centres for the City. On a tram, mothers could have perambulators carried, but there is no such facility on a bus, so it is suggested that health centres should be so located that there is no need for a walk of more than half a mile to reach one.

Dr. Parry is the first medical officer of Health to hold a professorship on the staff of a medical school in this country. As such he emphasizes the need for a sound foundation of knowledge if real progress is to be made in the health services of this country. In the report published a year ago of a committee of the Society of Medical Officers of Health, of which Professor Parry was chairman, special reference was made to this point. "One thing is certain," it states, "that unless the records department is properly established there can be no satisfactory progress towards developing the collection and analysis of morbidity statistics." Connected with an adequate arrangement for keeping and maintaining records is the provision of libraries both for the public health service and for the general practitioners. The latter seems to be a necessary accessory of any group provision for the general practitioners, although they already have access to the medical school library. Because it has dwelt on this point, the report must not be thought to be limited in its scope, for it covers the complete working of health centres and may be regarded as an authoritative guide to the whole subject.

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Registration Now Under Way in B.C. for Provincial Hospitalization Plan

ALL residents of British Columbia are now required to register in connection with the new Provincial Government Hospital Insurance Plan. This first step toward the implementation of the plan, which is scheduled to go into effect in January, 1949, is compulsory regardless of the individual's financial status. When the records are complete, exemptions will be made in the case of those people living in an area where the provision of general hospital service is not yet practical, members in good standing of the Christian Science Church, and those who belong to a private hospital insurance plan which provides benefits and payments to hospitals approved by the Hospital Insurance Commissioner.

Benefits

The new plan will provide public ward accommodation, including special diets, operating room facilities, surgical dressings and casts, x-ray and laboratory services, physiotherapy, and certain prescribed drugs. There are no strings attached to the number of times (or total length of time) a patient may go to hospital so long as hospitalization is necessary. There is no waiting period for maternity benefits and there are no conditions concerning illness preexisting the date when benefits become available. In cases where illness occurs outside the province, the hospital which treats a person so insured will be paid at a rate fixed by the Hospital Insurance Service. This insurance does not include treatment for diseases for which provision is made in government or municipal institutions, treatment for conditions provided for under the Workmen's Compensation Act, cures for alcoholism and drug addiction, outpatient care, or non-essential hospital care.

Premiums

The premiums to be paid by participants are as follows: $15.00 per annum for single persons 16 years of age and over; $24.00 per annum for head of a family with one dependent; and $30.00 per annum for head of a family with more than one dependent.

The head of a family may list as dependents: children under 16 years of age; those sixteen or over and dependent because of mental or physical infirmity; and those over sixteen but under twenty-one who are attending an educational institution. Grandchildren may also be included if they fall into any of the above categories. This also applies to brothers or sisters, brothers-in-law or sisters-in-law if the participant is financially responsible for them. Other dependents who are covered if financially dependent upon the head of the family are: parents or grandparents, including parents-in-law and grandparents-in-law, sons and daughters, including sons-in-law and daughters-in-law.

If premiums are paid in full by December 1st, 1948, the participant will enjoy full coverage for the year 1949. If paid on the instalment plan, the participant has full coverage to June 30th until the final payment is made in March.

Premium payments are expected to total $10,000,000 annually, a figure which will not pay for the actual cost of hospitalization. The provincial government and municipalities will continue to make contributions based upon the number of days of service provided by the hospitals. A considerable portion of the amusements tax will be paid into the Hospital Insurance Fund. An additional fund known as the "Hospital Insurance Stabilization Fund", amounting to $2,000,000, has been authorized by the provincial government to meet any unforeseen emergencies.

Change of Address

Readers are asked to note the new address of the British Columbia Hospitals Association. The registered office of the Association is now, 129 Osborne Road East, North Vancouver, B.C. For those who wish to contact them by telephone the number is North 919L.

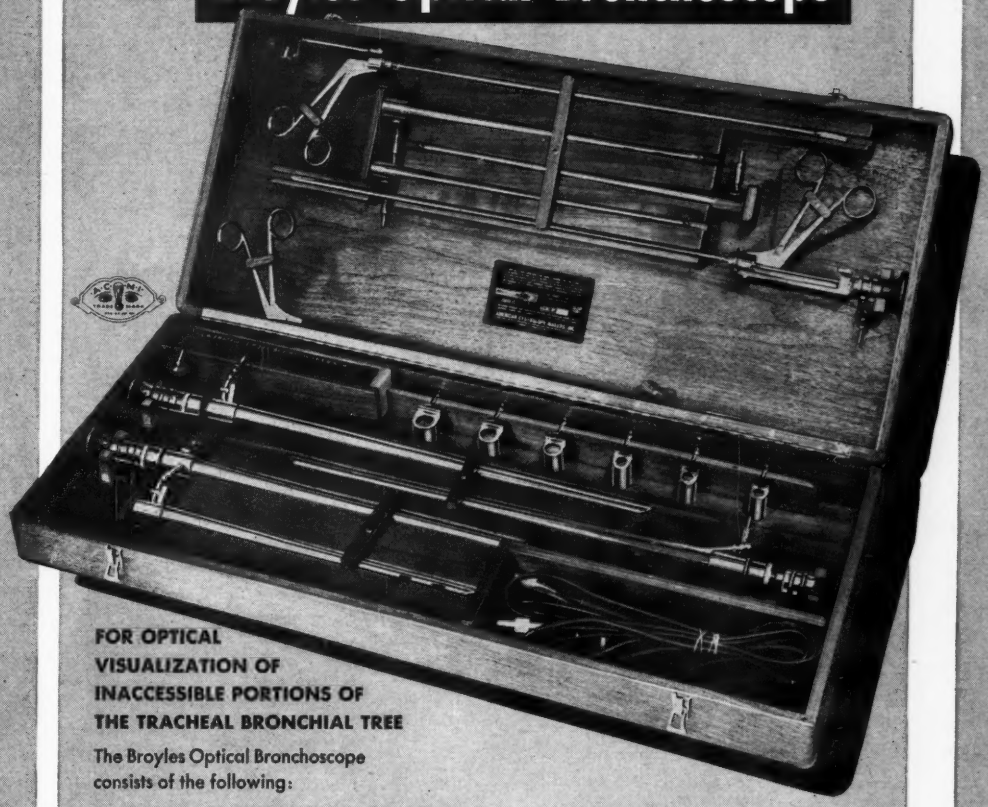
Michael Joseph McHugh, M.D.

Dr. M. J. McHugh, for many years superintendent of the Toronto Hospital, Weston, died on August 27th after a long illness. He was fifty-seven years of age.

A graduate of the University of Toronto, Dr. McHugh had been on the staff of the above sanatorium for twenty-nine years. He was appointed superintendent in 1937, a position which he held until his retirement last year. Throughout his career he had been active in the hospital field generally and in various phases of social service. He was a past president of the Toronto Hospital Council, a past vice-president of the Ontario Hospital Association, a member of the board of management of the Ontario Plan for Hospital Care and a Fellow of the American College of Chest Physicians. He had been a director of the York County Children's Aid Society and was a past chairman of the Crippled Children's Committee in Rotary.

Dr. McHugh is survived by his wife, the former Helen Rowe, and a daughter Helen Mary; also two brothers, Thomas and Hugh McLean, and a sister Jane who live in Ireland.

THE Broyles Optical Bronchoscope



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Here and There

The Charm of Lower Quebec

THIS summer our quest for a satisfying summer holiday again took us to what is to us one of the most delightful regions in Eastern Canada. Naturally views vary on this subject, but in our opinion few places can compare with the north shore of the St. Lawrence between Quebec and the Saguenay. This region (Charlevoix county) is mountainous and rugged. Roads deign to follow easy valley courses but cross the ridges as they meet them. Fascinating early French type houses, snowy white with gay trimming, dot the hillsides, and the mighty St. Lawrence down below stretches off into the summer haze.

And of all the picturesque places on that mountainous "roller coaster" highway, the little shore village of St. Joseph de la Rive is still to us the most attractive.

Apparently comparatively few English-speaking people know of this place. Those who motor down to Murray Bay by the inland route miss it entirely. Those who take the river road from Baie-St.-Paul miss it, too. It is several miles down a narrow sideroad which starts near Les Eboulements and winds down a precipitous hillside to salt water some 1200 feet below. Those who do venture down usually wonder how they will ever get their car up again—but they always do.

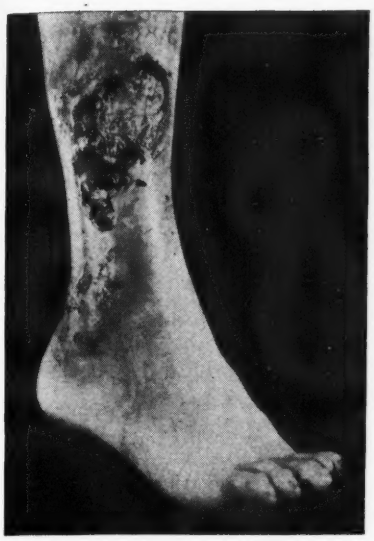
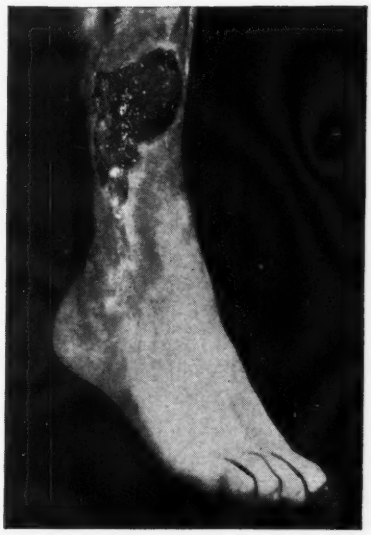
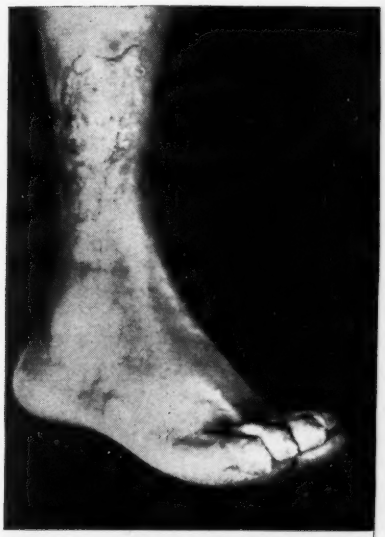
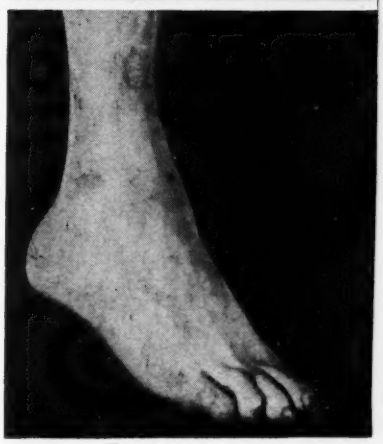
The straggling little village, with well-painted houses, borders a long, winding street trying hard to find footing between the mountain and tide water. The road finally traverses a broader humpy pasture land to end at a long log-laden pier flanked by a fine sand beach.

Within a few miles of this simple village one finds endless variety. At one's door is salt water bathing and the unfailing interest of a tidal shore —the musical "clunk" of logs being loaded into river freight "bateaux" and a daily procession of freighters from divers lands beyond the seas. Now and then glistening white porpoises delight the eye and occasionally a seal slips along. To one's side is the soft clatter of the mower in the salt marshes or the sound of the hammer coming over from the little shipyard near the creek mouth. Birds are everywhere and, as in other parts of the province, wild flowers such as purple loosestrife, yellow hawkweed and fireweed grow in a profusion seldom seen elsewhere in this country. Behind and above are glorious mountain trails through the woods and berrypatches, and over the crest roads lead to the many picturesque villages of this area—St. Urbain, St. Hilarion and Ste. Irenee—and, if one's interests in life have been stultified by oversophistication, to golf and dancing at Murray Bay.

To the writer there is continuous satisfaction in the solid, perfectly proportioned old houses of Quebec. Nowhere has he seen a style of home architecture more pleasing than these old buildings, usually dazzling white with steep pitched roofs, uptilted at the eaves, and with shutters and trim of gayest colour. Even in the decay of unpainted old age, these houses still preserve their majesty. It does seem too bad that other people in Canada cannot develop some of the enthusiasm of our French-speaking confreres for good design and uninhibited use of colour.

Unfortunately, many of the newer buildings show the dubious influence of modern trends, for all too many of them, as in other provinces, are just nondescript boxes bearing that aura of artificiality and lack of solidarity created by poor designing and the use of ubiquitous asphalt siding in imitation brick.

But it is the people who are most interesting. Kindly and hospitable, they make one feel very much *chez nous*, even though conversation with the villagers was usually limited to ultra-basic French. Actually we found that other visitors, practically all French-speaking, had an excellent grasp of English and, as a gesture of cordiality, insisted upon using it in our presence. Perhaps we would have made more progress with our French had they not been so considerate of us. The industry of these people, including the polite youngsters with their dogcarts, the spotless appearance of their kitchens, the good taste of the women in clothing, the fine cooking, their interest in good music and their delight in simple pleasures—all can be a stimulating example to the rest of us. In one attractive farmhouse visited on the return trip, the farmer proudly showed us a fine oil painting in the parlour done in a familiar style. Sure enough the signature was that of a leading physician-painter of Montreal!—*H.A.*

Picture the patient's progress

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Hospitals Lack Uniform System For Computing Bandage Costs

RESULTS of a nationwide survey conducted by *Hospital Management* have disclosed the need, in the majority of American hospitals, of a uniform system for computing the charge to patients for major bandaging and plaster casts.

Although a great many hospitals have a specific charge for diverse types of casts and bandages to which they add a small percentage to pay for use of hospital facilities, a good many other institutions have been unable to work out any standard system whatsoever, for establishing fair bandaging charges. In some hospitals a uniform rate for plaster of paris casts is set; in others, however, there is no charge for the specific cast, but the fee is computed by the amount of material used.

Compute Costs

At random, let us see how some of the hospitals compute their bandage costs. In one Wisconsin hospital, the regular charge amounts to the material cost plus 50 per cent for room and help needed. The administrator of another hospital states that here the charge is a "definite amount for each plaster bandage used, depending on size. This is fair to the patient, as he pays a set price for each bandage. A charge for the use of the room is made on all cases."

Charges for major bandaging and plaster casts in some hospitals are set individually by the physician. On the other hand the administrator of an eastern Michigan hospital computes costs "by charging for the use of the emergency or cast room, plus the cost of the material used, plus 10 per cent of the material cost".

Minimum Charge

A minimum charge of 50 cents has been set in the emergency department of a Chicago hospital. All major bandaging and cast work is charged roughly at two-and-a-half times the cost of materials.

One example showed a sliding scale for plaster casts from $3.00 to $10.00 depending on the part of the body, therefore the amount of material used. It is worthy of note that in this case the hospital also considers the financial ability of the patient to pay.

A sound method has been developed in one hospital for determining its charges for bandaging. The hospital adds 20 per cent to the actual cost of the bandage, then a $2.00 charge to cover "sheet wadding, stockinette, et cetera, for ordinary size casts; $1.00 for small casts such as wrists or ankle".

"The only adequate way," one administrator knows of is to charge for roll bandages at a per bandage price, which is "in addition to operating room charges". Orthopaedic operating room charges at this institution ran from $10.00 to $25.00 with an adequate description of what cases fall into each charge classification.

Determine Costs

Mr. F. R. Ostrander, administrator of an Illinois hospital, believes, in regard to plaster casts, "that too many hospitals make an arbitrary charge for this service. We have set up a rate," he states, "based upon the number of plaster bandages used, including the cost of the nurses' time, administrative cost, and the use of the cast room. We have figured these out on the basis of lower leg, full arm, body, et cetera." This formula, he thinks, would likely assist any hospital to determine the correct and adequate charges for such service.

In those hospitals which do have definite charge rates, costs of gauze bandages ranged from 25 cents to $1.00, cost of arm casts from $2.50 to $10.00, cost of leg casts from $3.00 to $10.00, and cost of body casts from $7.50 to $25.00. One Methodist hospital which, although it makes its charges "according to amount of bandages required and time to put on casts and bandages", has a separate rate for private rooms and ward patients".

Leonard Hamblin, assistant superintendent of an Ohio hospital, declared that a definite scale for cast charges has been worked out in his hospital. "There are no set charges for major bandaging in the treatment room. Charges for all extras are made in addition to $1.50 for use of treatment room. Most cases requiring major bandagings go to surgery where charges are made accordingly."

Drawing a conclusion from the systems used for computing plaster of paris bandaging costs in the emergency and orthopaedic rooms of American hospitals, the author suggests that an institution which has no definite system for deciding charges for this service might do well to set up the following procedure. Determine how much material goes into the assembly of each type of cast, find the cost of this material, then add to the cost a fixed percentage for nursing service and use of hospital facilities.

This would provide the hospital with a standard charge for each type of plaster cast. Hospitals which base their charges on ability of the patient to pay could make reductions accordingly.

Condensed from an article by Jules K. Joseph in "Hospital Management", Jan., 1948.

A Criterion of Civilization

Civilization is a very complex phenomenon. It has both material and spiritual aspects. A nation may produce great painters, poets and philosophers but cannot be considered truly civilized as long as its infants die like flies and the mass of the people live in misery and starvation. Nobody, on the other hand, would consider a society civilized merely because it had attained a high standard of living and good health conditions. Civilization requires the cultivation of all those spiritual values that make life truly humane and thus worth living. The part that medicine can play is limited, yet medicine is important because it greatly contributes to human welfare and helps to create conditions for the development of culture.—*Henry E. Sigerist.*

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Care of Old People and Chronic Invalids

A Medical and Social Problem

Dr. Manuel Moreno

THERE is one phase of public health and social security of which one hears relatively little; the medical, social, economic and simply human importance of it has been generally underestimated, at least in European countries. It is the question of chronic invalids and old people.

According to British statistics, 29 per cent of chronic invalids are less than 65 years of age and 10 per cent less than 45. Nor are they all incurable or entirely incapable of activity. On the other hand, not all old people are invalids. However, there is no clear line of division between the two and so it is convenient to study the health and social problems of these groups together.

By chronic cases we mean all those with a continuing pathological state which will not necessarily affect their life-span, which does not require specialist care and which is not contagious. This definition excludes from our discussion the infirm, including blind, deaf and mute, disabled persons (civilian or military), tuberculosis and cancer patients, and the mentally ill, for all of whom there are special institutions. Such a division is, of course, not scientific but it serves to distinguish the chronically ill who are fairly well looked after from those for whom little or nothing is done.

The latter are divided into several medical categories. According to French and British statistics 26 per cent of them are paralytics, 10 per cent heart cases, 5 to 6 per cent rheumatism or arthritis sufferers, the remainder being made up of digestive ailments, lung troubles (other than tuberculosis), diabetes, eye diseases (other than blindness) et cetera. It is chiefly a question of illnesses subject to seasonal or periodic aggravation. Between these periods such people are capable of a certain amount of activity. But they hasten to hospital when they have a "bad spell", a complication, or simply when winter sets in, and stay there until spring. After a few such sessions the chronic patient becomes an encumbrance and the hospital either refuses to admit him or directs him to a charity institution.

In the present state of affairs, the old person, whether or not he is ill, is in much the same position from the time when he cannot provide for his own needs. And the institution, in addition to its other unpleasant aspects, often entails separation from the old person's wife or husband.

The problem of old people, from the threefold viewpoint of medicine, society and economics, is all the more serious since their number is steadily increasing in European countries. In France, the number of people over 70 years of age almost doubled between 1851 and 1936. In England, in 1900, there were 1,750,000 over 65 years of age. In 1937, there were 3,750,000. The proportion of those over 60 to the active population is now 1 to 3 in France. About 1970 it is expected to be 1 to 2. In these circumstances it is impossible to count on the "old age" contribution paid by the employed people, however high the rate, as being sufficient to ensure decent pensions for all the aged. So, until there is a change in the population curve, it will be necessary, on the one hand, to permit old people to work as long as they can and, on the other hand, to make their keep after that time as little of a burden as possible for the general population. This naturally also applies to chronic invalids.

The shelter, in this respect, is a basically wrong solution for it condemns all inmates indiscriminately to idleness and robs them of spirit and ambition.

But what should take its place? For there is no arguing the fact that old people and chronic invalids must first of all have a place to live.

Some propose the creation of "health homes", "rest homes" or "welcome centres" for chronic cases. These would not be shelters or asylums but would still be "specialized" establishments. Others, especially the British, believe that, if the chronic invalids were treated by the same institutions and the same personnel as the acute cases, many of them would improve to such an extent that they would need no more long stays in hospital. In either case, the chronic patient needs frequent if not continuous medical attention and society can do more for him than merely provide him with a bed and cursory treatment. These people are delicate and susceptible to cold. Winter, fog, wind, dampness, and lack of sunshine, are their worst enemies. They should have the benefit of the most favourable climate and living conditions, as well as opportunity for thermal treatment. The establishment and extension of thermal hospitals is absolutely necessary in this regard. And finally, when the chronic invalid is placed in the best possible health conditions, the social services must see that he is reclassified as to occupation so that his work will suit the state of his health and enable him to lead a productive life for as long as possible.

For old people, as such, the problem resolves itself into one of providing pleasant surroundings. There are both advantages and disadvantages to be considered in the matter of large and small retirement homes, or individual cottages where old couples can enjoy some freedom and independence and still have the medical and social care they need.

Here, as in so many other fields, the essential problem is to attract the attention of the authorities, to interest public opinion by means of an educational campaign and to fight against indifference, routine and scepticism.

Food is at its best the instant preparation is completed. Preparation "on the spot" and in small quantities is the solution.—*Muriel J. Westney, Dietitian, St. Joseph's Hospital, Toronto.*

Courtesy of Service d'Information Francais, Ottawa.

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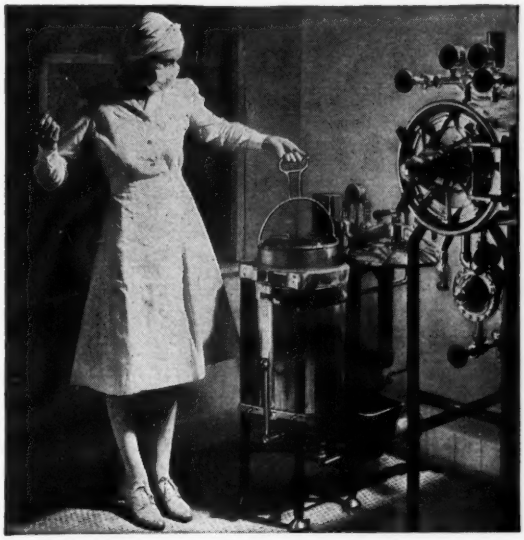

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Health Care Plans

Blue Cross Enrols over 31 Millions

The A.H.A. has announced that more than 31 million people are enrolled at present in Blue Cross hospital service plans. After a second quarter growth of 964,926 new members, enrolment for the period ending June 30th topped the first quarter mark by 71,081 to become the fourth largest second quarter growth in the history of Blue Cross.

The total enrolment of 31,210,819 was divided between the two nations as follows: U.S. (including Puerto Rico)—29,016,080; Canada—2,194,739. On the basis of the latest available census figures, 20 per cent of the U.S. population and somewhat more than 18 per cent of the Canadian people are covered by Blue Cross.

* * * *

New Ontario Benefits Meeting Subscriber Approval

The report of the Ontario Plan for Hospital Care, at the end of July, indicates a very satisfactory changeover to the new rates. Acceptance of the new rates and augmented benefits has been almost unanimous, only a small proportion of the subscribers retaining their old contracts until expiration dates. Enrolment at the end of July had increased to 1,171,452 participants.

Hospitalization charges are still rising and in July amounted to $553,202.44, the percentage of income utilized being 82.2 for the month. For the year to date some 3½ millions of dollars have been paid out, or approximately 95.6 per cent of subscription income. This very high utilization of income was largely due to the steady rise in hospitalization charges and the fact that the new rates were not put into effect until July 1st. It is anticipated that the next six months will reveal a stabilization of this effect.

Total enrolment and general expense for July amounted to only 12.4 per cent of subscription income. The average length of stay was lower than usual, being 7½ days. The staff has been increased to a total of 386.

* * * *

Blue Cross to Withdraw in British Columbia

In view of the implementation of a provincial government hospital insurance plan in British Columbia, the Blue Cross plan in that province, known as Associated Hospitals Services of British Columbia, will withdraw from the field in December of this year. The recently announced government plan of hospital coverage is not expected to be financed by the personal contributions, the balance being contributed by the province as a whole, as is the case in Saskatchewan. Consequently all restrictions can be eliminated, making it exceedingly difficult for a voluntary plan, which must balance its finances, to compete. As the government plan is compulsory for all those not already carrying hospital insurance, further expansion of a voluntary plan would be very difficult.

Premiums for ward accommodation are considerably higher than those charged in some of the Blue Cross plans in Canada. This has been made necessary, in all probability, because of the unlimited coverage and the anticipated usage.

The other Blue Cross plans in Canada will not be affected by the decision in British Columbia.

* * * *

A.C.S. Approves Ontario Blue Cross Film

"Peace of Mind", a colourful 16 mm. sound film produced by Plan for Hospital Care, Toronto, Ontario, now includes the following legend within the body of the film: "Passed by the Committee on Medical Motion Pictures of the American College of Surgeons."

"We are indeed proud and honoured," remarked Mr. D. W. Ogilvie, deputy director of the Plan, "in hearing of the acceptance of this film by the American College of Surgeons. 'Peace of Mind' was produced primarily to portray to the citizens of this Province the need—and the answer to—a plan for hospital care."

"Peace of Mind" has been shown to over 115,000 people throughout the Dominion and to several thousand in the United States.

* * * *

Effective Advertising

The Blue Cross Commission and the American Hospital Association have adopted a particularly effective method of advertising their services. Postage meter ads appear on the official envelopes with pithy slogans such as "Health Banker for Millions" and "Serve and Support Your Hospital!"

In Canada, too, some hospitals are using mailing machines to tell the story of the Plan in a similar way. The newest quarterly slogan is "Blue Cross Benefits have Increased", now featured by the Ontario Plan in the school slate design. As a service to hospitals who would like to cooperate, the Plan would be glad to send an electro upon receipt of the name and model number of the mailing machine.

* * * *

"The Case of Mrs. Conrad"

A new *March of Time* documentary film, "The Case of Mrs. Conrad", produced by the Twentieth Century Fox Corporation, under the auspices of the American Hospital Association, is now being shown in this country. The film takes the audience "behind the scenes" in a typical modern hospital and shows how science has replaced the distress and discomforts of surgery with new miracles of healing and swift convalescence. "The Case of Mrs. Conrad" has a strong human interest appeal and constitutes a splendid public relations effort, made on behalf of voluntary hospitals.

The picture is running in Ontario this month, under the sponsorship of the Ontario Hospital Association and the Plan for Hospital Care. It will appear in other provinces across the country throughout the fall months. Since the film is authentic and is of value as a means of public education, hospital executives might well draw attention to their own institutions through promoting this picture when it is shown in their community.

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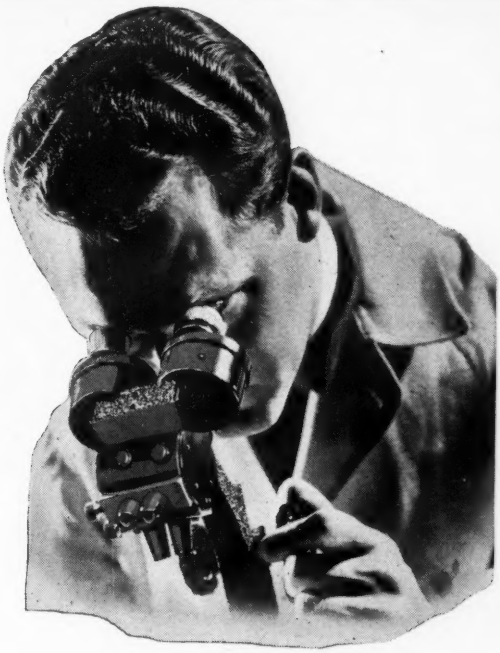

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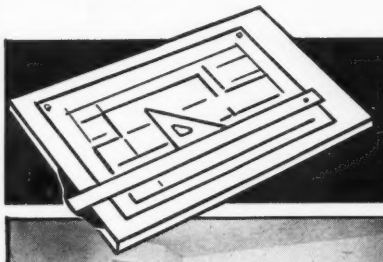
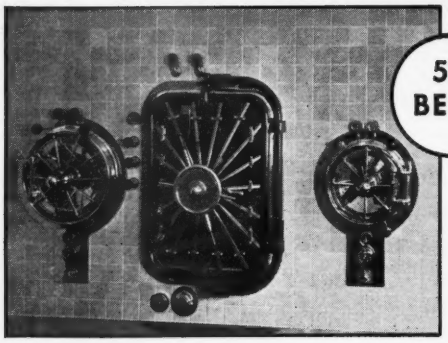
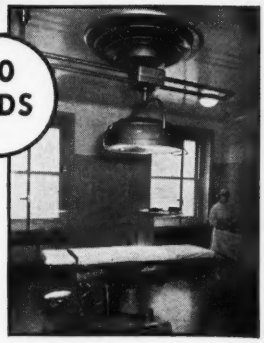
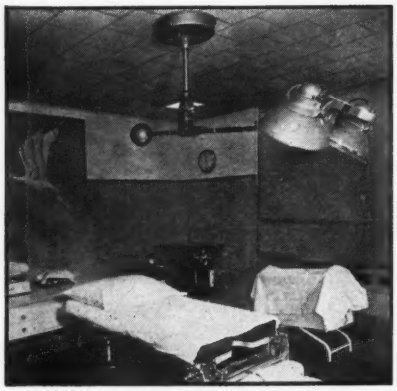
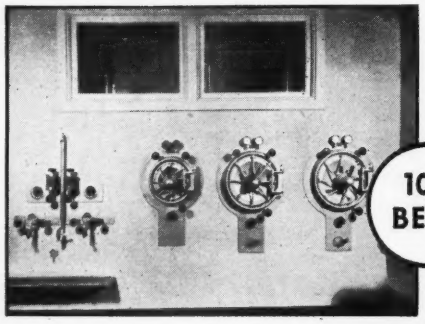


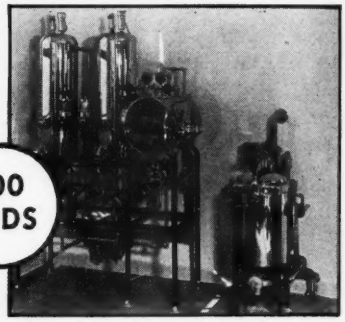
WHATEVER SIZE HOSPITAL IS ON YOUR BOARDS

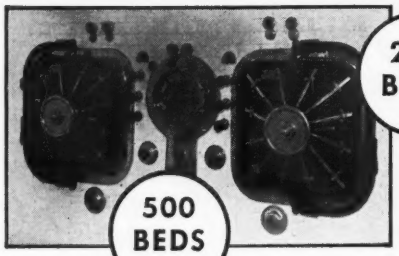


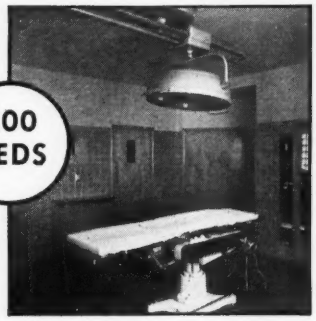


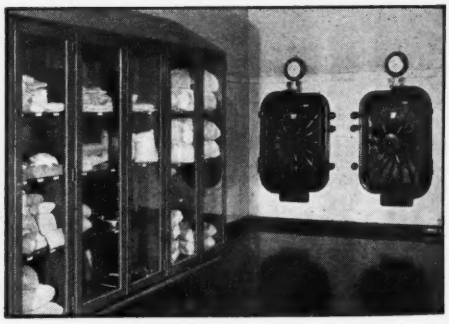












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57
QUALITY

Provincial Notes

British Columbia

LANGLEY PRAIRIE. Over 1000 persons attended the official opening ceremony of the new 38-bed Langley Memorial Hospital. The $196,000 hospital, made possible to a considerable extent by the voluntary contributions of the community, is neither municipal nor provincial, but is owned by the 1030 members of the Langley Memorial Hospital Society.

* * * *

VICTORIA. Reconstruction of the Strathcona ward of the Royal Jubilee Hospital will provide a new children's ward with fifty per cent more accommodation for children of all ages and modern treatment facilities. Large windows on all sides, a skylight over the corridor and extensive use of plate glass in the partitions will assure a bright cheerful interior. A sunroom is provided for convalescent children and ramps from each of the doors permit stretchers and wheelchairs to be taken out on the lawn.

One-third of the total cost, $40,000, has been promised by the provincial government, one-third has been subscribed, and approximately $13,000 has yet to be raised in order that accommodation will be available for sick children during the coming winter.

Alberta

CALGARY. As part of its welfare program, the Calgary Gyro Club has undertaken to equip a $1,200 hospital room for the Salvation Army Booth Memorial Home. Bed, medicines and other sick room necessities will make it suitable for the regular examination and care of children.

Manitoba

BOISSEVAIN. Last month Boissevain paid tribute to its war dead at a dedication service of the new Boissevain Memorial Hospital. Over $50,000 was collected by voluntary subscriptions from the municipalities of Boissevain, Morton and Whitewater, and the town of Minto to which the 10-bed medical nursing unit will extend its services.

* * * *

CARBERRY. Nearly 100 persons from Carberry and the surrounding district were present on August 4th when the foundation stone for the Fox Memorial Hospital was layed by Mrs. T. Fox, who donated the hospital buildings and grounds. The estimated cost of the hospital is $65,000.

* * * *

MINNEDOSA. Residents in the Minnedosa district have approved wholeheartedly plans for the construction of a new $130,000, 30-bed hospital. Full operating and diagnostic facilities, plus nursery and maternity wing, will be provided for in the new building. The project will receive a grant of $42,000 shared by the dominion and the province, and a $3,000 grant from Manitoba Pool Elevators, the remainder to be raised by direct taxation.

* * * *

NEEPAWA. As a fitting war memorial, it has been decided to construct a 34-bed hospital in Neepawa and a six-bed nursing home in Glenella. The maximum cost of both projects is to be $200,000 and the government is to provide $80,000 of the cost of the hospital.

* * * *

WINNIPEG. The newly appointed superintendent of Grace Hospital, Brig. Miriam M. Houghton, assumed her duties in July, duties which entail management of the entire hospital including staff, and all department and institutional work. A graduate of Vancouver Grace Hospital and administrator for 20 years in Salvation Army hospitals across the Dominion, Brig. Houghton succeeds Brig. Pearl M. Payton, who has taken the position of territorial secretary for social work of the Salvation Army in Canada.

Ontario

BRAMPTON. Plans for the $250,000 addition to Peel Memorial Hospital have been approved by the hospital board of governors and the Peel County Medical Association. The extension will provide for 38 beds and 29 nursery cubicles, a laundry, and a heating plant. Arrangements have been made for an x-ray table, while the county tuberculosis association has donated an x-ray machine to provide free services to county residents.

* * * *

GRIMSBY. Replacing the structure which was destroyed by fire last January, the new $180,000 West Lincoln Memorial Hospital is now under construction. It is expected that the hospital will be completed and ready for use by spring of next year.

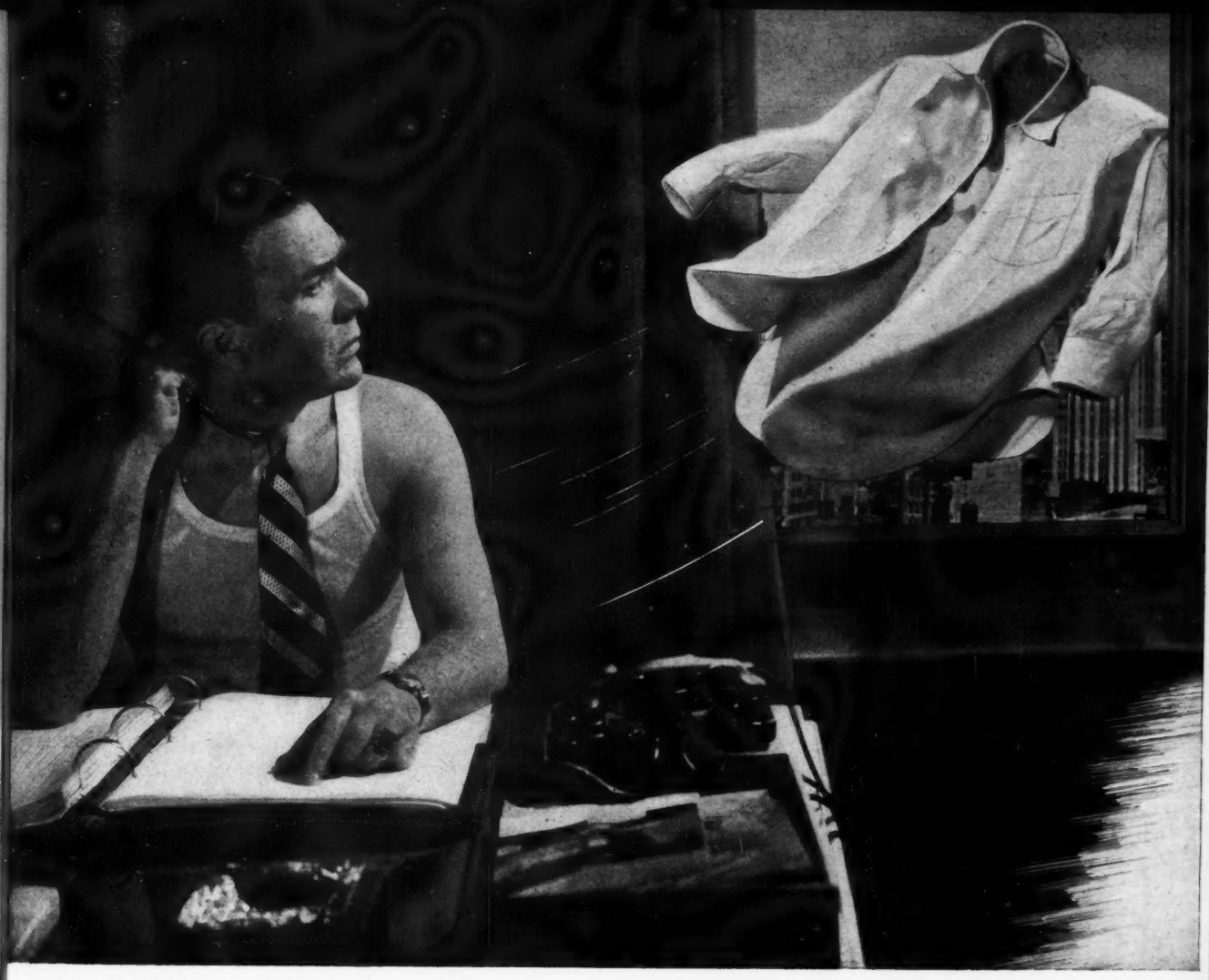
* * * *

KINGSTON. Accommodation and facilities at St. Mary's-on-the-Lake Hospital for incurables are being extended and improved. Alterations, amounting to almost $100,000, will involve mainly the fitting for hospital purposes of an existing extension at the rear of the four-floor building. The addition of 65 beds, and the installation of an elevator, a permanent ambulance delivery ramp, a therapeutic room, a central supply room, and a chaplain's suite will be included in the renovation plans.

* * * *

OAKVILLE. Architects have drawn up plans for a 50-bed hospital which will be constructed shortly. The two-storey building is to be of fireproofed construction and is estimated to cost, including the equipment, $390,000. Up to the present, the federal government has contributed $100,000 and the province, $40,000; communities in the district to be served by the hospital have aided by debenture issues.

(Continued on page 108)



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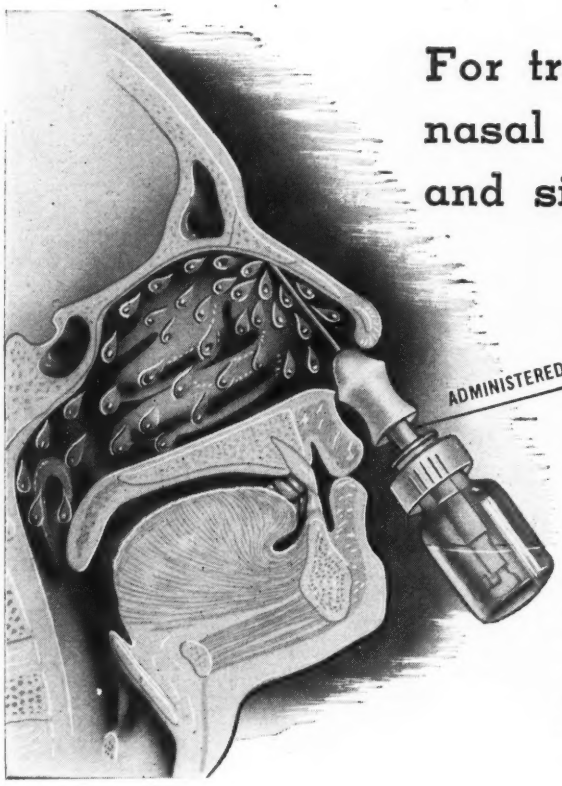

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Medical Records

(Continued from page 31)

tient, or why this operation restored him to health is more valuable than negative knowledge. That is, the house surgeon is more interested in learning what to do than in discovering what should not be done.

In Practice

The foregoing has laid out what may be considered the essentials of record taking. We should now consider the practical manner in which these records may be completed. The admission sheet should, preferably, be made out by the admitting clerk at the time of the entrance of the patient and before the patient is sent to the ward. Such procedure is not only good practice, it is essential if collection control is to be carried out by the hospital accountant. Emergency admissions always pose a minor problem for the admitting office. Not infrequently a maternity case or accident casualty enters hospital, occupies a room, or may have treatment administered before full details can be secured. In hospitals it must be remembered that efficient treatment of the sick may create difficulties in establishing rigid office routine. Much of this problem is solved by having information or admission sheets issued only by the admitting officer. It is then required that details concerning the case be given by relatives, by the patient himself, or by the nurse-in-charge before the chart can be officially begun. The patient is thus given a hospital serial number and information essential to the business office is on record from the first day in hospital.

The doctors' order sheet should follow the information sheet or admission form. All orders for treatment or therapy should be written and signed—an elementary safeguard against errors. Whenever medications other than ward supplies are called for, these should be requisitioned on hospital prescription forms. These medications may then be secured from the pharmacy or stores department.

Compiling the Chart

All written reports should be signed by the nurses making the entries. This not only serves to "localize" errors in nursing technique, but it stimulates the nurse to "be certain" before she writes her report. The charge nurse is usually held responsible for arranging that the chart is complete, in good order and follows along from day to day. It is desirable that laboratory reports, x-ray examinations and other serial procedures should be kept in chronological sequence at the back of the chart. This may be neatly and simply done by gumming these reports in order on a piece of plain paper or manilla card. Cellulose tape is useful for this purpose. Other examination sheets and records are inserted in the order in which they are performed.

The chart cannot be considered a full legal record without a clinical history written by the physician. This is largely a matter for control by the chief of the medical staff. However, the securing of adequate case histories is not infrequently a vexing problem for any hospital. On one occasion the late Sister Patricia of Duluth Hospital was asked by Dr. Malcolm MacEachern how she was able to achieve this co-operation from the medical staff. Her original reply shows the strategy required in this problem. She said, "When I find a bundle of unfinished charts belonging to any doctor I go to the surgeons' cloak room and steal his hat. I then tell him that I shall certainly keep it until the last of his histories is finished and turned in to the record library".

What Shall We Do With Them?

When the patient is discharged, the chart should go to the record library or filing office. Here the clerk should carefully check over each chart, put all forms in even order, staple the sheets together and insert these in a manilla binder. Unfinished or incompleted charts should be set aside for the notice of the attending physician. When the charts have been prepared in this manner a record number is given corresponding to the discharge date. A ledger or cross index is kept listing all charts under name of the patient, admission date, discharge date and serial number. Thus a chart can be found from only partial information as to identity. It is frequently very desirable to maintain another cross index for the benefit of investigation or medical research. The Standard Nomenclature of Diseases and Operations is both simple and precise for this purpose and it is possible to use small index cards to list the numbers of charts of patients having the same or allied conditions. A thorough understanding of this method of filing is a valuable asset to any hospital record clerk.

Let the value of the medical chart never be argued or the worth of the permanent record denied! In these days of W.C.B., D.V.A., Blue Cross, and numerous hospital plans, the patient's record must be readily available and frequently inspected. Its value as a medico-legal record is great and nothing in the law will relieve the hospital from the responsibility for keeping good permanent records. And yet the problem will arise "Where shall we put this immense volume of paper which increases like the national debt from year to year?"

It is wise to have definite cut-off periods so that each year charts of certain age will be removed further and further from the front line of the record library. A chart may be considered current for perhaps three to five years. Charts from five to ten years old may be stored on shelves or in orange crates by months and years in some reasonably accessible place. Care should be taken that these remain in chronological order and if records are removed for examination a red sheet with these particulars should be inserted in place of the absent record.

The really ancient records constitute the greatest difficulty. At regular intervals these may be examined and as the record becomes of less interest the less vital information may be pruned from the charts. Usually T.P.R. sheets may be destroyed without loss to the record and frequently medications and minor treatment bear no relation to the facts of the case. It is possible by means of such a pruning system to reduce ancient records to very small space. It so becomes a simple matter to preserve these in vaults or have them copied to micro-film and then destroyed.

The Hospital Committees of the American College of Surgeons have long insisted that the quality and order of the medical record is a faithful portrait of the standard of any

(Concluded on page 78)

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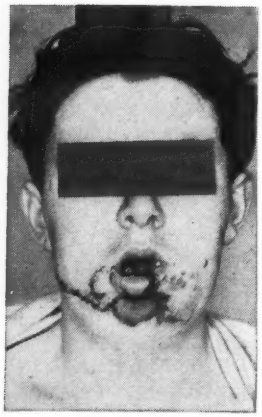

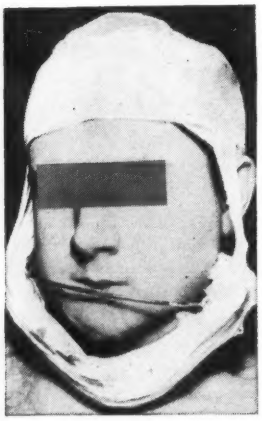

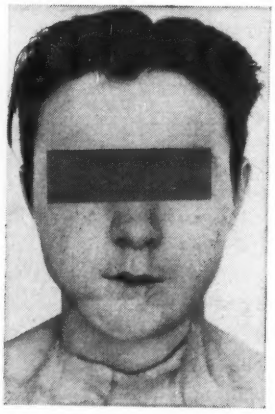

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CASE-HISTORY—The patient was injured in July, 1941, when his ship was bombed and machine gunned. Examination showed the lower lip divided and a loss of soft tissue of chin and of mandible from right molar region to left incisors. On August 29th, 1941, two tube pedicles were raised on the neck. These were lengthened four weeks later. On October 22nd the scars were excised from the face and the two pedicles attached.

November 11th, 1941—The pedicles divided.

February 24th, 1942—A bone graft was inserted.

June 26th, 1942—An acromio thoracic tube pedicle was raised.

July 22nd, 1942—The pedicle lengthened.

July 31st, 1942—The pedicle attached one end.

September 24th, 1942—The pedicle attached the other end.

February 2nd, 1943—A further bone graft was inserted with Gypsona P.O.P. headcap and plaster between each pair of pins.

October 20th, 1943—Chin dimple made.

The details and illustrations are of an actual case. T. J. Smith & Nephew Ltd. of Hull, England, are privileged to publish this instance typical of many in which their products have been used with success.

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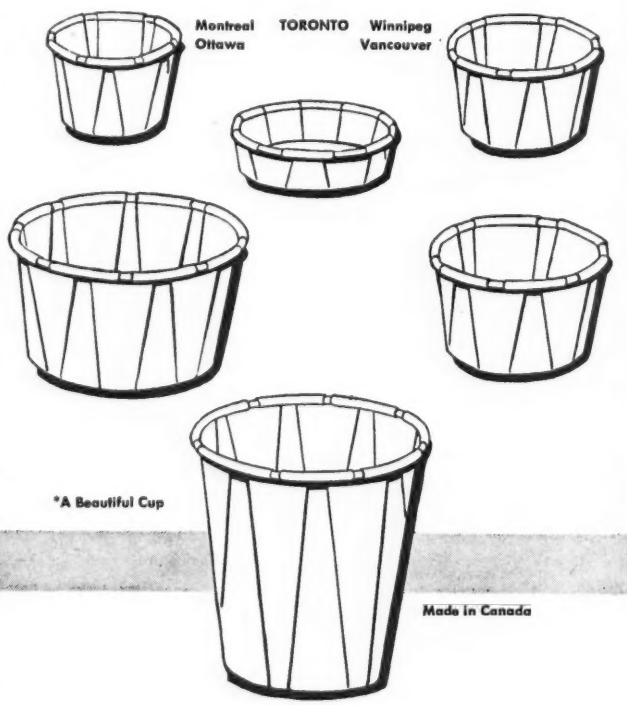

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—Daniel Webster, 1825.

Home Care

(Concluded from page 48)

ately. This is due largely to the fact that the burden is shared with the family in the matter of housing and feeding.

Summary

Those responsible for the Home Care program feel that it has a special appeal as a suitable, humane, and economical method of care for selected patients. In addition to the material saving it affords, many patients benefited psychologically by the return to their home and individualized care. An average of thirty-five beds in the hospital were made available for patients requiring intensive hospital care.

A further extension of all services is continuing this year, including physical and occupational therapy. As the program develops it will include the patient who can afford the services of a private physician but not expensive hospitalization. (See Obiter Dicta.)

Medical Records

(Concluded from page 74)

hospital. Since the days of Hippocrates and all through the centuries of growing medical knowledge, contributions to the healing art have been made largely through the written word. Harvey, Sir William Osler, Cushing, and all great figures have been exactingly accurate about their records. Let us be no less faithful in this duty to those who follow us.

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On Hospitals—S. S. Goldwater, M.D.

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Stores Department

(Continued from page 33)

sidiary of the purchasing department.

Stores Records

The actual task of receiving materials from the various delivery services should be, if possible, the assigned duty of one member of the stores staff. The procedure of accounting for items received may be adequately handled in several ways, so long as full advice on all goods entering stores is carefully noted and forwarded to the accounting and purchasing office. A separate form may be used, registering in triplicate the name of the firm from whom the goods were received, the date of entering stores, description, and exact quantities of the materials delivered and countersigned by the receiving clerk. Optionally, use may be made of the triplicate and quadruplicate copies of the original purchase order for the goods now being delivered, whereon, through a simple carbon arrangement, the exact quantities ordered have been omitted. The receiving clerk will, of necessity, have to check the incoming goods and note on the space provided, for forwarding to the business offices. The latter method obviates considerable extra writing on the part of the receiving clerk.

A complication attendant upon this method, particularly prominent in the last few years, is that of short shipments. In this case, a simple back order form may be introduced which will remain on the storeroom receiving file after the quantities on the balance of the order have been carefully checked and entered on the copies of the purchase order form for forwarding to the business office.

To ensure correct classification of the many items entering central stores, it has been found advisable to originate a system of assigning code numbers to each article of stock other than perishables. A common numerical system will serve, but it is usually advisable to combine the numerals with an alphabetical prefix to denote the separate sections in the stores department. This is particularly applicable in the case of surgical supplies such as instruments, enamel or holloware, sutures and dressings. The judicious use of code numbers will simplify considerably the task of the accounting office in maintaining adequate perpetual inventory records. Great care should be exercised in the stores department to see that all advices for receipt or issuance of goods carries the correctly assigned code numbers, in order to prevent endless back-checking of differences between perpetual and physical inventory records.

The stores department may simplify the requisitioning of supplies by the preparation of a catalogue for internal use only, containing an accurate description of the supplies carried in stock, with the specific assigned code numbers clearly set out. The time taken by many telephone calls and endless personal enquiries may be saved through a careful application of this procedure.

Requisitions

The common instrument for drawing upon the stores department is the requisition, which must be carefully designed to serve a threefold purpose:

1. Obtaining needed supplies;
2. Maintaining perpetual inventory stock records;
3. Providing the cost of supplies delivered to the requisitioning department.

The proper use of requisitions should be thoroughly understood by all heads of departments and subordinates responsible for their preparation. Each requisition should clearly denote:

(a) Quantities delivered;
(b) Quantities requisitioned;
(c) Description and catalogue number of goods required;
(d) Space for value extension of goods delivered;
(e) Signature of clerk filling requisition;
(f) Signature of person receiving goods requisitioned;
(g) Approval by senior administrative officer.

Theoretically, requisitions should be prepared in duplicate or triplicate, with separate copies for the accounting office, stores office and department requisitioning supplies. The practical danger in such an application is the possibility of changes in the original requisition and consequent oversight on the part of the storekeepers' department to note fully such changes on all copies. With care, a single copy requisition will meet operating requirements and always carry the complete story of a transaction. Here the problem is the possible loss of one copy, with resultant complete loss of the information contained thereon.

Wherever possible, the common practice of using a bin card for recording stock received and issued on an individual item basis should be utilized in the storeroom. This record provides invaluable information should differences arise between perpetual and physical inventory records.

The necessary advice supplied to the accounting office, relative to stores issued from the storeroom, may be dependent upon the size and quality of your stores staff.

Where you have a number of departments requisitioning supplies daily, the postings in the perpetual inventory records may be materially reduced through the preparation, from the individual requisitions, of a collated daily work sheet of all items issued from stores. This work sheet may be prepared in the storeroom and forwarded, together with the requisitions, to the accounting office, where periodic spot checks will be made to ensure that the collated quantities are correct. On the other hand, the perpetual inventory records may be posted from each individual requisition.

The requisitions in the accounting office will be extended from the values shown on the perpetual inventory records and the total value of the various types of goods indented will be charged against the respective departments in your departmental cost records (figure 2). The problem of valuing a certain line of goods where the acquired price varies is often perplexing, but the most practical solution would appear to be the use of an average price. This is obtained simply by taking total stock (old and new) on hand, and dividing total value (old and new) to arrive at an average unit cost of the stock on hand.

To eliminate indiscriminate and haphazard requisitioning, it is often advisable to assign certain definite days for the ordering of supplies by the various departments. Optionally, certain days may be assigned for the

(Continued on page 84)

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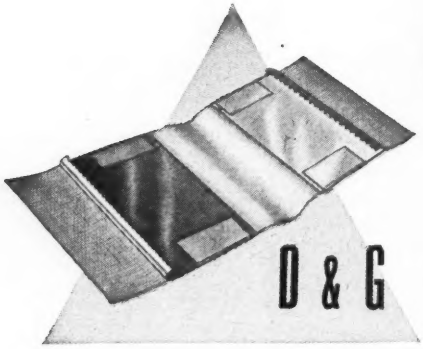

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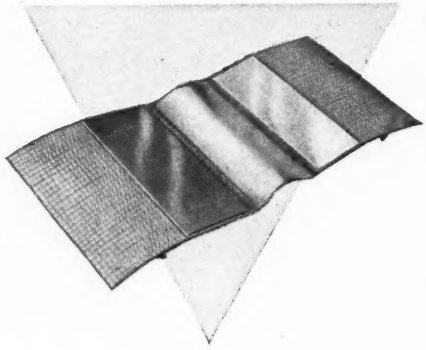

Traction is supplied by a sheet of latex connecting two metal members which grip the skin by means of fine-toothed edges, providing firm anchorage with minimal discomfort. TRACTACLIP can be readily removed for wound inspection.

- a wound approximator that exerts a gentle, continuous traction on the edges of gaping wounds. It enables the surgeon to effect, through this traction, the desired approximation of tissues. Some of the various uses of TRACTACLIP* Wound Approximator are...
- as an emergency dressing to reduce bleeding and secondary contamination.
- to narrow the gap gradually and help replace lost skin by elongating the skin on either side of the wound.
- to prevent retraction of skin's edges while a contaminated wound is being prepared for secondary closure.
- to relieve traction on skin sutures when the wound has been closed under tension.
- to reduce the area of raw surface and protect it from contact with overlying gauze.

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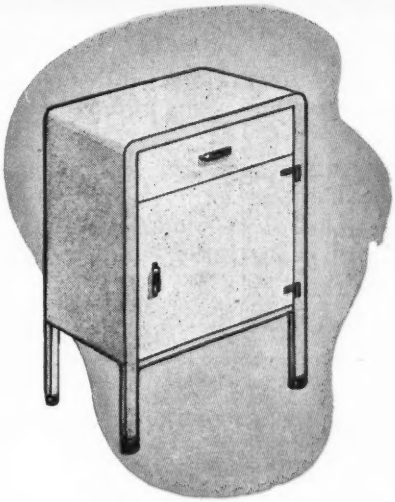

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So light yet so strong . . . fabricated from fine steel (tubing wherever practical) . . . sound-proof insulated . . . smooth-running rubber tired casters . . . special roller-drawer slides . . . easy, noiseless operation of all units assured at all times.

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Stores Department

(Continued from page 80)

issuing of specific supplies to all departments. Either arrangement simplifies considerably the work of stores and accounting departments. To obtain a satisfactory application of either of these regulations, it is necessary to have adequate and proper facilities for short-term storage of supplies in each department of the hospital.

In order to maintain effective administrative control of operating expenses, requisitions should be carefully scrutinized and authorized by a senior administrative officer before requisition is completed by the stores department. Likewise, all requests for purchases from the storekeeper to the purchasing agent should be authorized by the administrator or his immediate assistant.

Periodically, certain departments will wish to return items to stores and such a transaction should be carefully entered on a proper form. In most cases, such returns should be credited to the department and entered as an addition to stock. Economies may be effected by requiring departments requisitioning surgical equipment such as holloware or enamelware, instruments, rubber hot water bottles, syringes, et cetera, to return the worn out or damaged piece of equipment before issuance of a new article is permitted. In this case, such articles will not be taken back into stock except when repaired and restored to active use.

Inventories

While it is true that centralization of stores in one location under competent direction will achieve a strong measure of control, one must always bear in mind that goods represent a liquid asset and the accounting of supplies received and issued should be undertaken thoroughly and carefully in order that at any time during the year the true value of stock on hand is readily available.

Perpetual inventory records should be kept by the accounting department, irrespective of any records maintained in the central stores department, because a storekeeper should not be placed in the position of maintaining a control on his own dealings with materials and supplies.

To meet the requirements of the new accounting schedules of the Provincial Department of Health (Ont.), a perpetual inventory record designed to record receipt and issuance of supplies, by both quantities and values, is almost essential. These records will also greatly assist in arriving at a true monthly picture of operating expenses, as only the value of goods actually issued will then be charged to the respective commodity or departmental expense accounts. Figure 3 shows a sample of a simple perpetual inventory record which we use in connection with our mechanical bookkeeping procedures. A separate card is made out, with accurate descriptions of each item in central stores. From a carefully prepared physical inventory, an opening "receipts" entry is made as to quantity, value, and unit cost. Each day, items received in the stores the previous day are posted as further receipts and deliveries from the stores are posted as issuances, automatically recording balance on hand. This feature should

IMPROVED TORSO MODELS

√ **Dissected to provide a wide range of anatomical models.**

√ **Practically unbreakable — made of a special latex rubber composition that withstands shocks without suffering any substantial damage.**

√ **Contains no hygroscopic materials that might cause cracking or chipping.**

√ **Painted with specially prepared lacquers and enamels—can be cleaned with a damp cloth without damaging the finish.**

L-3000 FEMALE TORSO MODEL. A life size model designed to serve as a comprehensive training aid. Chest and abdominal walls are cut in midline and hinged, and the organs thus exposed can be removed to provide a number of additional models. In addition, the heart opens for demonstration of the valves, and the lungs are cut to show the internal structures with an indication of principal tracheal branches. Female pelvic organs are also dissected.

Dorsal dissection exposes the vertebral column, from which two lumbar vertebrae can be removed. Detailed structure of the vertebrae, spinal cord and nerve foramina are shown. Head structure is also shown in detail, and the brain is removable on one side.

Mounted on a self rubber base ..... **Each $330.00**

L-3215 SEXLESS TORSO MODEL. Similar to L-3000, but slightly less than life size and without sex organs ..... **Each $287.50**

Prices in U.S.A. Canadian prices slightly higher.

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ADAMS

be fully utilized by the administrator in having continual spot checks made on various items in stores to ascertain that the physical count agrees with the inventory records. Where differences arise, a satisfactory explanation should immediately be sought from the storekeeper before any adjustments are made. Careful application of this principle should obviate any large number of differences arising between physical and book counts at the time of complete physical stock takings. A complete physical inventory must be taken at least once yearly, preferably every six months, by members of the staff other than the stores department.

The principles set out relative to perpetual inventories will apply to most items used in the hospital, with the exception of perishables, fruit, vegetables, butter, eggs, fowl, fish and meats, pharmaceuticals and fuels. The proper handling of pharmaceutical supplies requires a very high degree of training. While originally received in the stores department, they are usually passed directly along to the hospital pharmacy. Expense adjustments on these items may be made on an estimate basis, verified once or twice a year by actual physical valuations.

Careful adherence to the principles set out in the several records at varying departmental levels should provide the administrator with effective control of the material and supplies used daily in the hospital. It is said that the term "organization" has been defined in many ways but, basically, the definitions have one thing in common in that organization is the *machine of management* in its accomplishment of the ends determined by administration. The methods of developing the machine and maintaining it are the primary tasks of the administrator. They may be established by costly trial and error procedures, or they may be devised economically by efficient planning and careful supervision. This is very true regarding proper methods of handling hospital materials and supplies. Regardless of what avenue of approach is used, the organization must always be under careful scrutiny and direction, for it will never be static but continuously on the move.

WHEN THE PURCHASING DEPARTMENT SAYS

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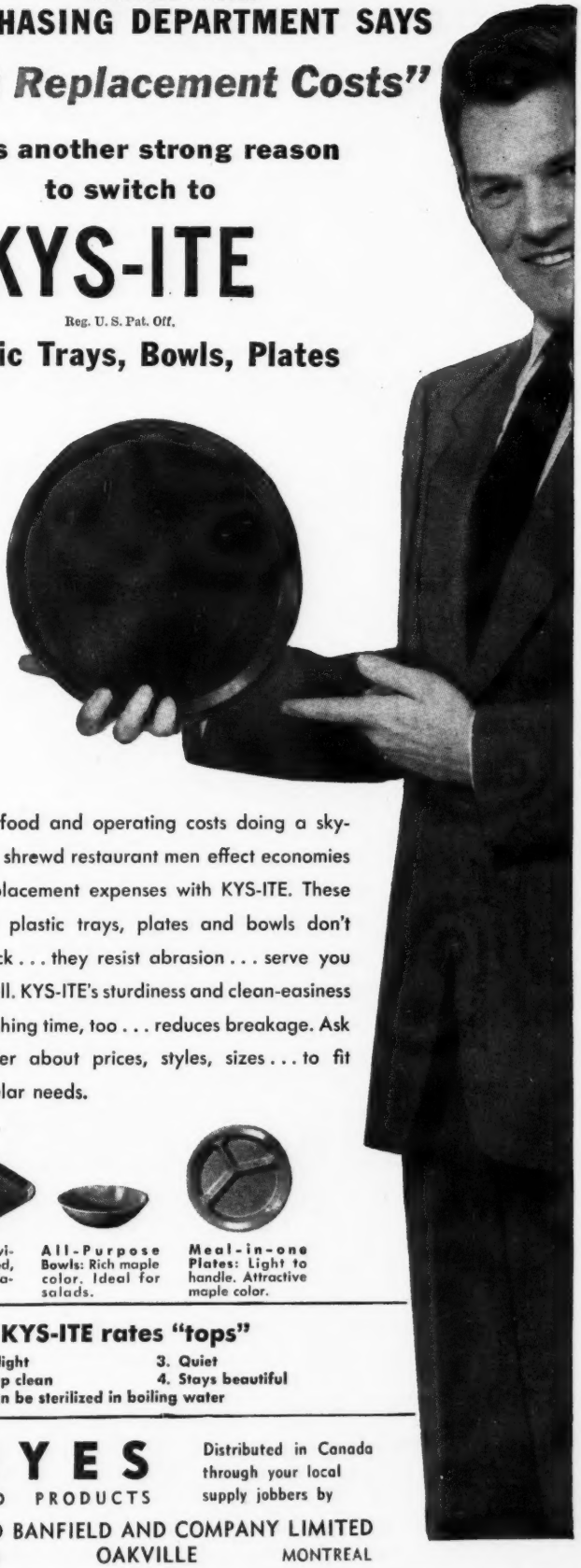
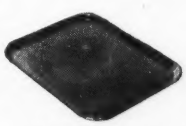
Plastic Trays, Bowls, Plates



With food and operating costs doing a sky-scraper act, shrewd restaurant men effect economies and cut replacement expenses with KYS-ITE. These rich-looking plastic trays, plates and bowls don't chip or crack . . . they resist abrasion . . . serve you long and well. KYS-ITE's sturdiness and clean-easiness cuts dishwashing time, too . . . reduces breakage. Ask your supplier about prices, styles, sizes . . . to fit your particular needs.



Trays: Cheery, vibrant colors—red, blue, brown. Variety of sizes.

All-Purpose Bowls: Rich maple color. Ideal for salads.

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2. Easy to keep clean
3. Quiet
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5. Can be sterilized in boiling water

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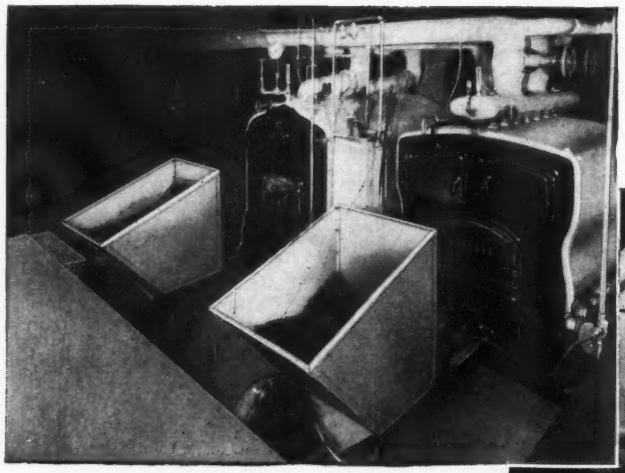
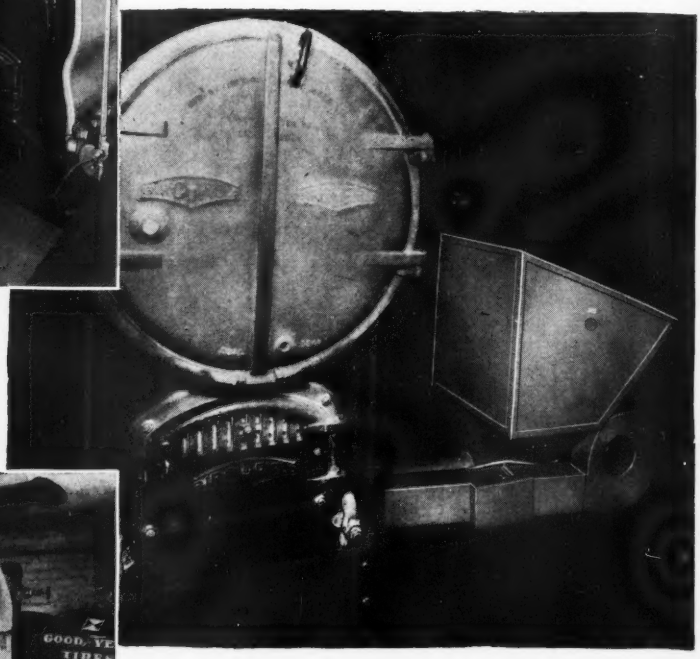


"SATISFACTORY PERFORMANCE LED TO INSTALLATIONS IN 3 OTHER SCHOOLS."

RIDGEWAY SCHOOL, NORTH VANCOUVER



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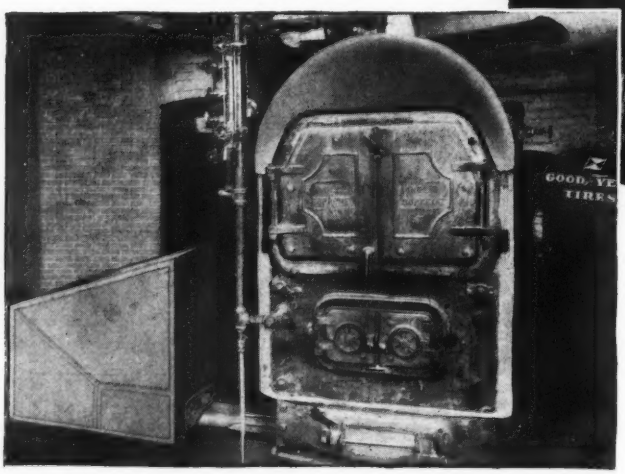

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Consulting Engineer — Paul De Guise
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Consulting Engineer—A. Edwards Simpson, Vancouver
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Plight of the Hospitals

If the voluntary hospitals are to survive their present crisis they must become the community's responsibility. This is the opinion of leading hospital authorities, according to the survey of voluntary hospitals made by this newspaper.

Hospital specialists are puzzled that people will spend millions of dollars on amusements and yet be reluctant to pay a much smaller amount for medical care. They wonder why hospitals, which are a matter of life and death, are of smaller concern to the community than a crippling snowstorm. They do not understand why hospital workers should be paid less than those doing similar jobs in industry. They make specific suggestions by which they hope to solve the emergency. They urge immediate aid in the form of increase of rates to patients, appeals to the public for contributions, further endowments, legacies and grants from foundations, higher per diem rate from the city, Blue Cross payments that more nearly meet regular charges, and efforts by the hospitals themselves to cut down costs in such ways as the more effective use of personnel and group purchasing agencies.

However, above and beyond temporary alleviation, they propose long-range attack. This includes comprehensive planning on three levels: by the individual in taking out Blue Cross insurance, so that he will be provided for in case of sudden illness; by the voluntary hospitals themselves, working as a group for more efficient service to the community; and lastly, by city, state and federal governments in co-ordinating plans with the voluntary hospitals to avoid duplication of effort and to provide for the greatest integration of health services.

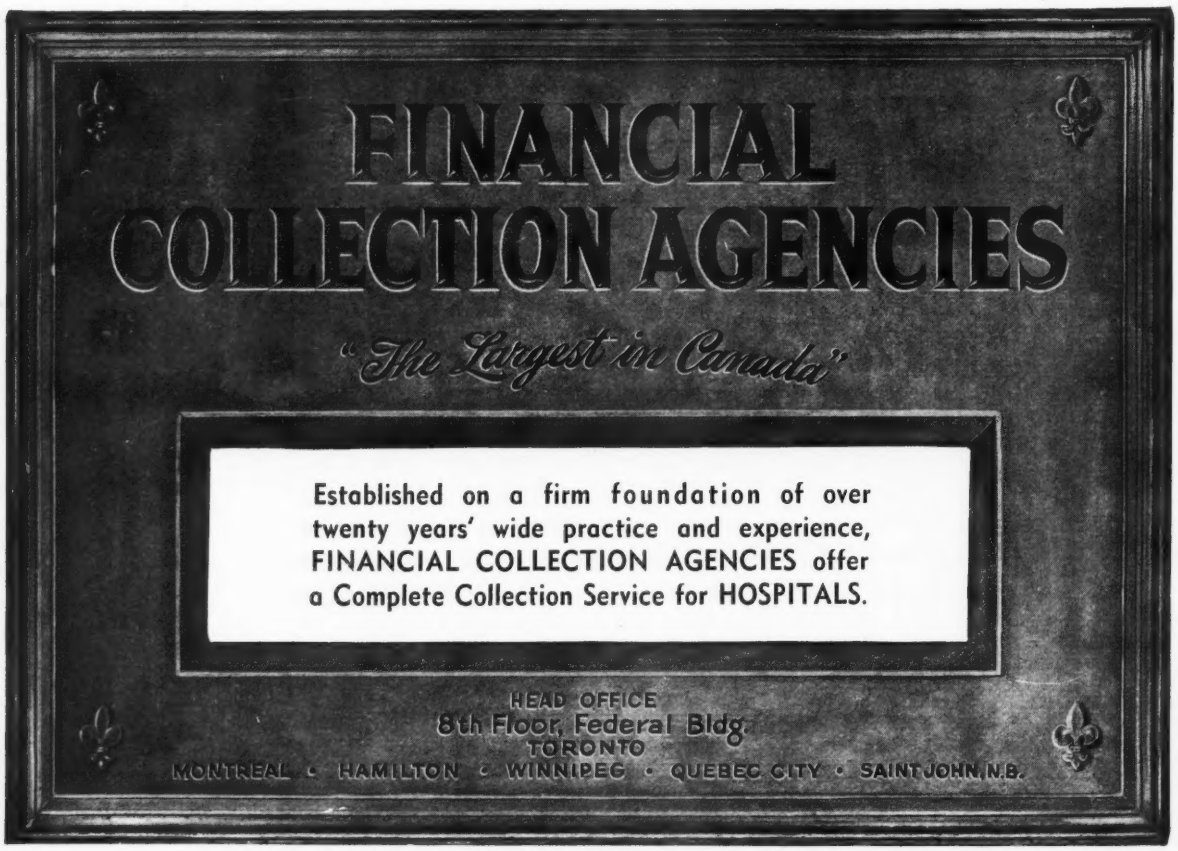
Action on each of these three levels depends in the last analysis on the same thing—the individual's support. The problem, at heart, belongs to each one of us. If the voluntary hospitals suffer, our community suffers. If they are forced to budget the amount of free care they can give, the medically indigent must be cared for in the municipal hospitals, which even now are staggering under a burden they cannot adequately carry. Certainly it is wiser to give immediate help to the voluntary hospitals than let them curtail services or collapse one by one.

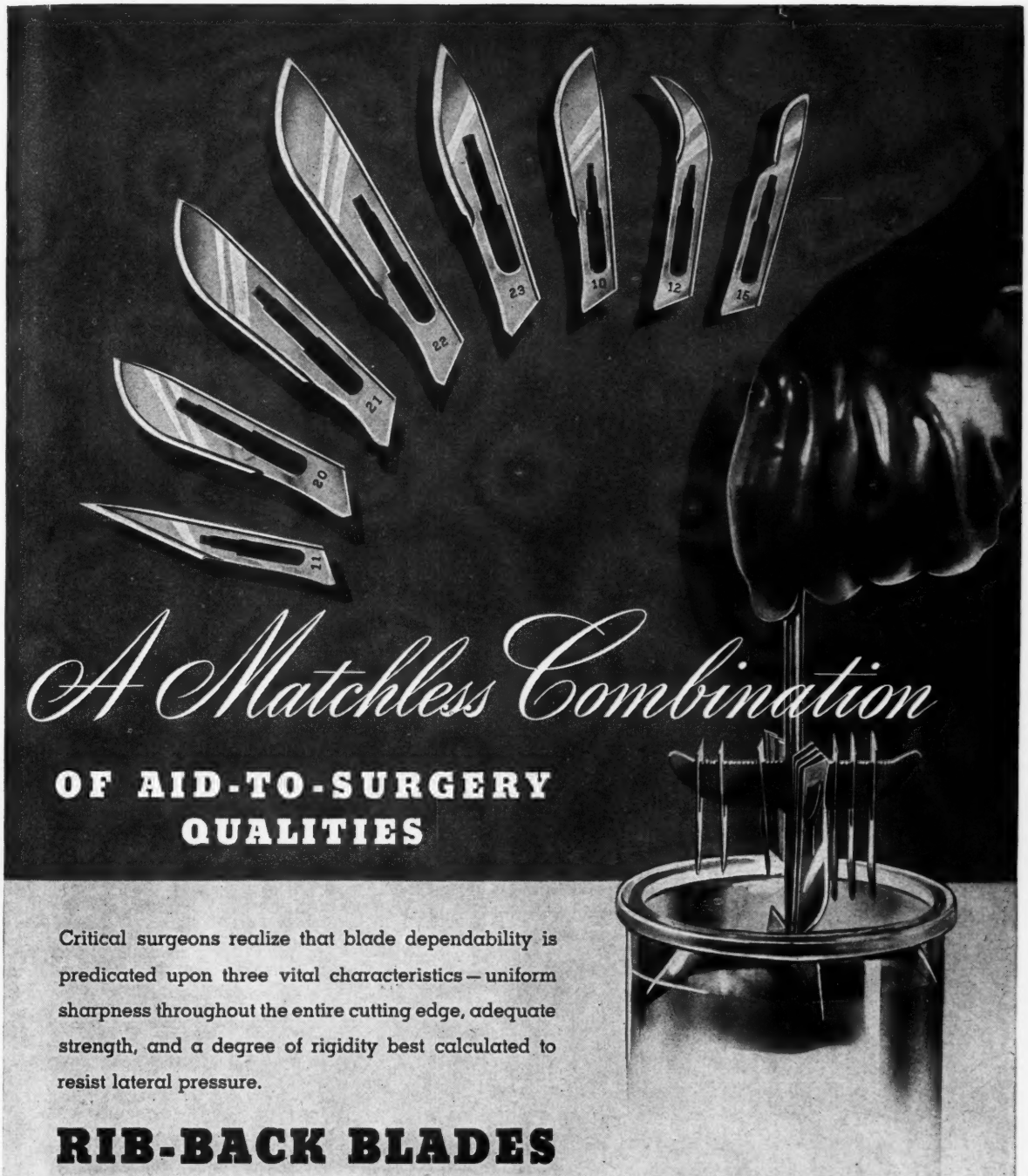
The voluntary hospitals need the support of all of us, in order that all may benefit. They must become "everybody's business".

—From an Editorial, "New York Times".

The Convalescent

To be sick is to enjoy monarchial prerogatives. Compare the silent tread and quiet ministry, almost by the eye only, by which he is served—with the careless demeanour, the unceremonious goings in and out (slappings of doors, or leaving them open) of the very same attendants, when he is getting a little better—and you will confess that from the bed of sickness (throne let me rather call it) to the elbow-chair of convalescence, is a fall from dignity, amounting to a deposition.—*Lamb.*





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Critical surgeons realize that blade dependability is predicated upon three vital characteristics — uniform sharpness throughout the entire cutting edge, adequate strength, and a degree of rigidity best calculated to resist lateral pressure.

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excel in all three essential requisites. They provide matchless uniformity . . . each and every blade assuring cutting efficiency at its best. Their uniformly superior strength is a matter of record. Their degree of rigidity is reportedly highly satisfactory to the surgeon . . . *a matchless combination of aid-to-surgery qualities.*

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Book Reviews

HOW LAYMEN CUT MEDICAL COSTS. Public Health Institute of Chicago. Pp. 35. 1948. Published by The Lakeside Press, R. R. Donnelley and Sons Co., Chicago.

For those who contend that state medicine is the only solution to the problem of making good medical attention available to all, this book records a remarkably successful experiment in self-supporting low-cost medicine.

It is the story of the Public Health Institute of Chicago, a non-profit venereal disease clinic under the guidance of prominent civic-minded laymen serving without compensation. During the 27 years of its existence, the clinic has examined and treated about 10 per cent of the population of the city. Not only has the Institute provided medical service at extremely low fees, but it has never turned away those who were unable to pay. Booklets, leaflets and posters have aided in the extensive program of public education and grants from surplus funds have been made by the Institute to certain universities for venereal disease research.

For those who wish to be informed, this is an enlightening account of how a clinic can, while giving inexpensive health service, remain wholly self sustaining, at no time accepting a penny of the taxpayer's money nor appealing to the public for contributions.

* * * *

INSTITUTIONAL COST ACCOUNTING. By Walter O. Harris, C.P.A., Chief Accountant, Public Administration Service of Chicago. Pp. 153. Price $3.00 (U.S.A.) Published by the Public Administration Service, 1313 East Sixtieth Street, Chicago.

To the student of cost accounting who is interested in large and complex institutions, this book offers much information of value. Originally published in 1944, and recently reprinted, this study is based upon a system installed in 1940 at the Eloise Hospital and Infirmary, Wayne County, Michigan, an institution caring for as many as ten thousand inmates which may be termed at once a psychopathic hospital, a home for the indigent and a general hospital. The book is illustrated with the various forms used, describes detailed procedures for obtaining a complete analysis of costs, direct and indirect, and contains general information that would well warrant careful attention.

Report on Hospital Accounting in Britain

It has long been evident that, with the establishment of the National Health Service in Great Britain, a new uniform system of accounting for all hospitals in the national service must in due course come into operation. According to a statement released by the Institute of Hospital Administrators, the present form of presenting accounts is inadequate in that it attempts to reduce all hospital expenditure to two units of costs, i.e. cost per bed and cost per outpatient attendance, and does not provide the means of proper comparison between different institutions, whose circumstances and services may be quite different.

With these considerations in mind, the Institute of Hospital Administrators, in co-operation with the Institute of Chartered Accountants and the Institute of Cost and Works Accountants, set up in July, 1946, a Joint Committee on Hospital Accounts, with the object of making a complete examination of hospital accounting and of formulating a set of accounts which could be applied to all classes of hospitals in the National Health Service. In addition it has considered the need for close correlation between any method of preparing accounts and the provision of general hospital statistical data.

The Committee's report, now published under the title *Report of Joint Committee on Hospital Accounts*, consists of five sections: General recommendations; financial records and accounts; salaries and wages and staff records; stores control and accounting; and statistical returns. The Report is obtainable from the Institute of Hospital Administrators, 13 Maze Pond, London, S.E.1, or through the library of the Canadian Hospital Council.

Safe Exercises

Miss Blofield, Professor of the Terpsichorean Positions, gives exercises in families and schools where dancing cannot be conscientiously admitted. Miss B. begs to state that her system of exercises may be practised with perfect safety, on account of the great gentleness of the method pursued.

—Advertisement in 1834.

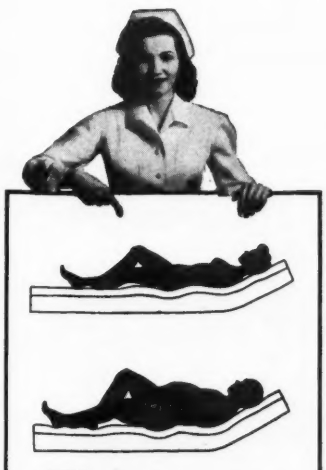
Controlled Comfort and Dependability

FOR LESS THAN 5¢ A WEEK

Special hinge-action construction makes Spring-Air easy to handle . . . hard to break down. Assures longer service than ordinary innersprings.

Thousands of Spring-Air Mattresses in Over 2000 Hospitals Have Given Comfortable Service for as many as 18 years

Hospital records *prove* the value of Spring-Air Mattresses, in "Controlled Comfort" . . . dependability . . . convenience, ease of handling . . . and economy. The best evidence of Spring-Air quality, in every detail of design and construction . . . and of the preference which leading hospitals have for Spring-Air hospital mattresses . . . is the satisfaction and enthusiasm of hospital users through the years. (Names of long-term users supplied on request.)



"Controlled Comfort," for every hospital patient, is assured with Spring-Air hospital mattresses! Spring-Air spring construction *automatically adjusts* to the weight of the patient . . . conforms to, and supports, the contours of the body—thereby aiding *every patient*, regardless of weight, in getting the best possible comfort and rest.

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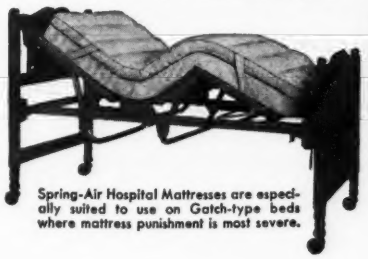

Spring-Air Hospital Mattresses are especially suited to use on Gatch-type beds where mattress punishment is most severe.

Spring Air MATTRESSES HOSPITAL . .

Write for illustrated folder of Spring-Air hospital sleep equipment . . . you'll see why over 2000 hospitals prefer Spring-Air.

Doing Your Own Flameproofing Pays

In the disastrous Boston fire a few years ago, highly inflammable drapes and other decorative material quickly turned the overcrowded night spot into a tinder box. To prevent such occurrences, many municipalities passed local fire ordinances. Most of these laws require that all drapes or decorations be flameproofed.

Curtains and drapes can be sent out for fireproofing. However, large savings can be effected by doing the flameproofing in the hospital laundry. Besides considerable savings to be gained by doing the flameproofing on the premises it saves time and effort by eliminating a number of operations.

In the flameproofing process the fabric is treated with a solution, as in treating for water repellency. This solution in the fabric prevents any flame from forming in the event of a fire by causing the formation of gas which in turn cuts off the supply of oxygen.

Flameproofing chemicals are produced under a number of brand names but it is recommended that the laundry manager use a solution which has been approved by an official agency. The type of chemical I have found most satisfactory for the job comes as a white, granular compound which looks similar to salt. One pound of this compound should be used to one gallon of water, the amount of solution to be made up depending upon the amount of material to be treated. Before treating the drapes or curtains with this solution, the usual laundering process should be carried out in the washing machine. After the washwheel has been drained, enough of the solution is added to circulate freely through the material. It is recommended that a low water level be used to keep the cost of the treatment down to a minimum; approximately a two-inch level in the washwheel is sufficient.

After the curtains and drapes are extracted, they are finished in the usual way. Ordinary, flat unpleated curtains can be put through the flatwork ironer. However, although the chemical is harmless, it may cause a little bit of sticking in the finishing. To overcome this on the flatwork ironer, two sheets may be passed in and the ironer stopped. Then the draperies can be passed between the two sheets and the finishing can be accomplished smoothly. Curtains with boxed pleats can be finished on the small utility press, and to eliminate sticking here a press cover should be placed on the top buck.

After the flameproofing has been completed, most municipalities require that an affidavit be executed. The laundry manager executes this affidavit after he has turned the curtains over to the housekeeper. After the affidavit has been signed and notarized, the hospital superintendent, or whoever is in charge of the building, notifies the fire department that the institution has complied with the law. The affidavit is kept and shown to the Fire Department official when he visits the institution on his regular round of inspection.

Drapes or curtains treated with a

Where uniformity counts

Rely on C-I-L

C.P. reagents

C-I-L Chemically Pure Reagents assure hairline accuracy in hospital laboratory analyzing and testing. Manufacture is carried out to specifications under the supervision of experienced **C-I-L** chemical engineers. Uniformity is assured.

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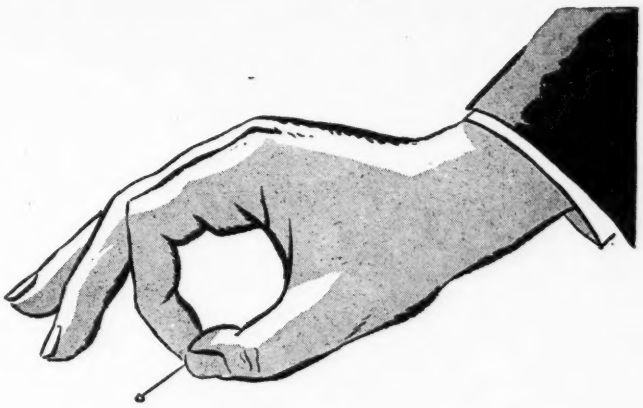
reliable fireproofing formula are guaranteed for the period of one year from the date of treatment. Since the compound is soluble in water, any curtains or drapes must be reprocessed if they are laundered in the interval, although the compound is durable to three dry-cleanings. Fabrics which must be dry-cleaned are sent out for special flame-proofing treatment.

The above solution used is completely safe for launderable fabrics and will not in any way harm the colours. It will not alter the handle of materials or make them stiff and boardy. Nor will it weaken or destroy fabrics or thread even after repeated applications or prolonged storage. It enables the laundry manager to offer another valuable service with a minimum expenditure of supplies and equipment.

—Robert Lawson, in "The Laundryman", Hospital Abstract Service.

Irish Moss Extract

Agar, which is produced from a Pacific Ocean seaweed, was used (prior to the last war) in large quantities by the food industries, especially in canning. Unfortunately, the Japanese controlled the world's supply of this material. Consequently, when active hostilities against that nation began, it was necessary to attempt to prepare a suitable substitute. The material selected for this purpose was Irish moss, a seaweed which is plentiful in Canadian waters. It was, in fact, found after a number of experiments on technical details of processing, that Irish moss extracts could be used as a jelling and stabilizing agent in foods and that with the addition of a potassium salt, the jellies produced were even stronger than those previously obtained from agar. Groups of individuals were unable to distinguish between the taste of canned chicken jellies made from the two substances. The moss extract is also used in chocolate milk drinks to prevent the chocolate from settling. It finds further use in the manufacture of ice cream and certain pharmaceutical preparations. It is hoped that the information and experience accumulated in these studies will help to establish a permanent new industry in the Maritime Provinces.—*J. W. Hopkins, National Research Laboratories.*



Why You Should Want to Hear a Pin Drop

When it is possible to hear the sound of a dropped pin—then you have surroundings in which disturbing noise is completely hushed.

No hospital can eliminate noise quite so completely. But neither can any hospital tolerate more than a minimum of noise. Quiet in hospitals is necessary to speed the recovery and discharge of patients and to help reduce the mental and physical strain on busy staffs.

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Hospital Beds and Cancer Control

(An editorial from the Manitoba Medical Review).

Now that the Federal Government is interesting itself in the hospital situation we can look forward to the day when beds will be available in hours rather than in days or weeks. It is likely that the local institutions are planning their extensions and it is probable that a University hospital will be erected. This latter is desirable as a means of co-ordinating teaching and of stimulating research. Its erection alone would release a number of beds and this would tend to quiet the fears of those practitioners who fear that they may lose hospital facilities.

But whatever is done it is certain that months or even years will pass before there will be available that number of beds which we now consider necessary. And before that time comes many things may have happened. Those who were in practice prior to the depression will recall that there was then a similar dearth of beds, a dearth which became an excess during the depression. It is a strange fact that prosperity brings over-work to doctors and hospitals, while in days of adversity both wards and waiting rooms are sparsely filled. What happened may occur again and it is possible that when we have available all the beds that we now want, many of them will remain empty.

There is, however, a matter within the scope of the Federal and Provincial Governments which is even more pressing than the supplying of more beds. It is easing the cost of diagnostic investigation. A few years ago such cost was tolerable, for most people were prosperous. But now that money is less plentiful the burden is great. This is especially true in the case of cancer which at the moment is the object of intensive propaganda. People are being made exceedingly cancer-conscious and doctors are proportionately cancer-suspicious. The value and benefit of such propaganda and such suspicion are shown by the success of their use against tuberculosis and syphilis. Routine chest films and routine Wasserman Tests have revealed many unsuspected cases and have done much to mitigate these scourges. But these tests and examinations cost the patient nothing. To investigate the cancer-suspect is expensive, and the individual himself must bear the cost. Moreover such investigation is almost of the nature of an emergency, it is so urgent.

Salvation Army to Construct New Maternity Wing in St. Johns

Faced by a long waiting list for admission to the wards and serious overcrowding, the Grace Hospital at St. Johns, Newfoundland, has launched a drive for funds to build a new maternity wing. The campaign will be opened by His Excellency the Governor, and the immediate objective is $75,000.

This year being the twenty-fifth anniversary of the hospital, the new wing, to be known as the Jubilee Wing, will provide 20 extra beds and will also release 10 beds in the present hospital, making room for 30 additional patients in all.

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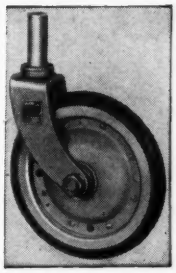

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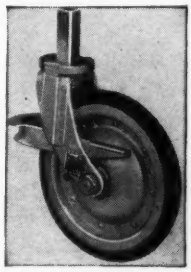

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Music Therapy for Children

IN planning an occupational therapy program for children it is important to realize that a period of illness interrupts the child's normal development. The occupational therapy program at Children's Memorial Hospital, Montreal, plans all group and individual activities, to insure, in addition to specific therapy, adequate opportunity for development of the child's manual skills, social sense and mental development. It has been found that music therapy offiers a flexible medium for group and individual treatments. The equipment includes a piano, a small pump organ, a portable electric phonograph, two hand operated victrolas, a record library of carefully selected music, and rhythm band equipment consisting of drums, tambourines, zylophones, cymbals, bells, triangles, and rhythm sticks.

Children who began their musical education prior to their illness are able to continue under the guidance of the therapist. In several instances the therapist has given a child his first piano lessons, thus paving the way for further development after hospitalization.

The novelty of the pump organ never fails to catch the children's fancy. It is taken onto the wards for group singing and is also used to provide exercise for the lower extremities. With some children the therapist plays the keys while the patient pumps; others are able to play the keys and pump simultaneously.

Twice a week a program of recorded music is provided for the patients on the ward. In spite of the variance in age groups, the record library offers sufficient variety to please the musical tastes of all. An account of each program is kept, and the children's reactions are noted. Nursery Rhymes and Mother Goose songs, Winnie the Pooh, the Green Eyed Dragon, Peter and the Wolf, and the Nutcracker Suite are among the favourite selections. A supply of old records is kept in the department which the children play on hand operated victrolas.

The Rhythm Band, conducted on the wards, is one of the highlights of the occupational therapy program. It aims to provide a healthy outlet for surplus energies within the limitations of the child's physical handicap and to develop a team spirit. For some of the children, playing in the "Band" offers further opportunity for specific therapy for impaired movement or co-ordination of muscles and joints. Each young "musician" gets a great thrill from his performance, no matter how unpolished his efforts may sound.

The Waterloo Rhythm Band Method is an excellent book to use as a guide for this project. Although it is written for normal children with pieces of music intended for piano accompaniment, the basic principles have been successfully adapted to meet the requirements of the mixed age groups and the variety of physical limitations of the chil-

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dren on the wards. In place of piano accompaniment, records are played on the portable gramophone. Marching and waltzing rhythms, as in "Anchors Aweigh", "The Whistler and His Dog", and the "Blue Danube", are popular with the children.

Still another type of music is unaccompanied group singing on the wards. Of a spontaneous nature, this less formal activity creates a cheerful break in the hospital routine. Group singing includes action songs, accumulative songs, rounds, folk songs, and singing games.

Music used in these ways is a therapeutic agent. With the therapist supervising the music in all its phases, the tendency for it to become a distracting interruption to the children's required treatment is obviated. It may well be that during the period of hospitalization many of the children are, for the first time, able to appreciate music in its true beauty. They learn that this is something to value and enjoy; it is not just another noise to combat.

—Condensed from an article by Mrs. Barbara Miller, O.T.Reg., in C.J.O.T.

On Forging Nurse Character

(From a graduation address by Dr. F. M. Christie at Galt Hospital, Lethbridge.)

The foundation of the tempering of the individual is laid in the home. There with love and care and Christian teaching, begins the sublimation of the gross elements. With this background you entered a profession which is based on the love of fellowmen. There continued the forging of the steel in each of you. With teaching, with discipline, with hard work, accepted because of the ideals of the profession before you, you have reached this great event of graduation. But tempering does not end when the doors of the training school close behind you. The process of development toward the integrated personality must continue. The greatest need in the world today is for individuals of sound character, individuals who will not break down under stress and strain, who will meet honestly and adequately every demand of the day's work. Without them, world chaos will result . . .

We have heard you take the Florence Nightingale Pledge. There is no higher standard for personal and professional integrity. It is a rebuke to the pseudo-realism that has sprung up in nursing in the past few years and has resulted in an apathetic work-a-day attitude. Yours is never a job. It is always a calling. You need a realistic working idealism—an idealism that springs from an inner strength, the steel of a true tempering process.

Nor is your professional ability enough, however good it may be. Without personal effort and a deep sense of responsibility it is useless. In the last analysis, the vital need of the patient is in your hands. Your integrity may be the last defence.

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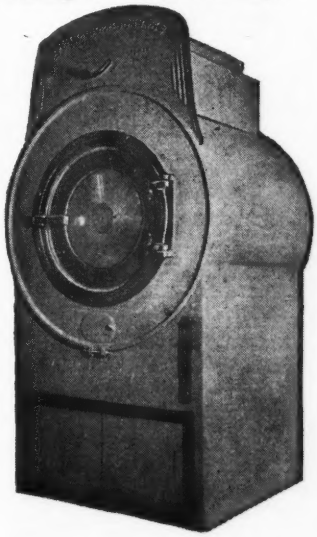

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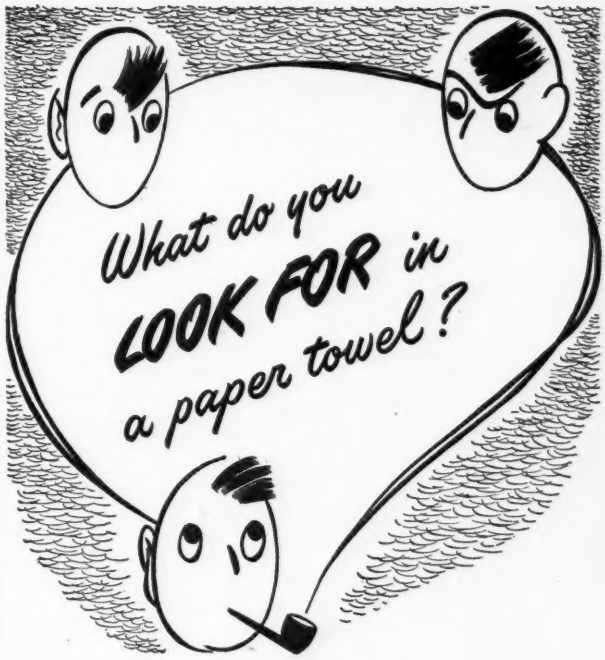

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Radiological Technicians Opposed to Union Affiliation

At the annual meeting of the Canadian Society of Radiological Technicians, held in Quebec in June, a resolution was adopted which indicated the desire of this group to remain outside any union activities. The resolution reads as follows:

"Therefore, be it resolved that we, as a Society, in open convention, make known the fact that we desire our membership to be exempt from enrolment in any or all branches of labour unions, and that we intend to take all necessary measures to bring this desired condition into existence."

At this meeting, also, a committee was appointed to study the possibility of developing national registration for technicians in Canada. The members of this committee are as follows: Dr. Desmond Burke, Christie Street Hospital, Toronto; Mr. Mel S. Smith, Shaughnessy Hospital, Vancouver; Mr. P. E. Hunt (Chairman), Regina; and Mrs. M. F. Cameron (Secretary), McGregor Clinic, Hamilton.

Further progress was reported in setting up facilities for the training of x-ray technicians. Two years ago a committee was empowered to undertake the establishment of approved schools of training. This committee is composed entirely of radiologists who are working in a co-operative manner to link together the ideals of the Society, and its Board of Examiners, and the ideals of the Canadian Association of Radiologists. Members of the committee are: Dr. A. C. Singleton, Toronto; Dr. Hill H. Cheney, Vancouver; Dr. E. A. Petrie, Saint John; Dr. Desmond T. Burke, Toronto, and Dr. A. E. Perry, Regina.

At this year's convention, considerable power was given to the Board of Examiners of the C.S.R.T. to take whatever steps will be necessary to raise still higher the qualifications and general calibre of its membership.

New Ontario Courses for X-Ray Technicians

As a step towards the objective of the C.S.R.T. to establish approved schools in Canada for the training of technicians, a program of training was embarked upon last year in Toronto, which, it is hoped, will be enlarged little by little to an established, successful program of training that should ensure recognition.

This program provides for refresher courses for radiographers, including a course in anatomy at the University of Toronto, which consists of 16 two-hour lectures one night a week, and a course arranged at Central Technical School where instruction in physics is given two hours one night a week for a period of about seven months.

"We are making a start," states Dr. Desmond Burke, "and with the proper response will develop it into a complete course—perhaps a university diploma, perhaps a technical school diploma. We hope it will serve as a foundation for a Dominion-wide standardized curriculum. And finally, we hope that it will provide us with the necessary notes or books so that we may give them a system and say. 'These notes or the following books cover completely a course for the Canadian diploma.'"

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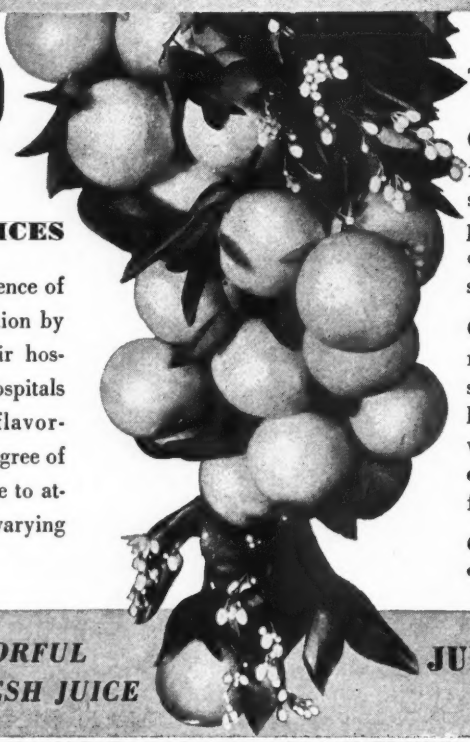

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Ontario to Increase Aid for Tuberculosis Accommodation

The Hon. R. T. Kelley, Minister of Health for Ontario, has announced that in the case of new hospital accommodation for tuberculosis care, the province will provide $2,500 per bed. As the federal government will provide $1,500 per bed for such construction, the combined federal and provincial grants for tuberculosis beds will now total $4,000 per new bed. The provincial assistance in new hospital construction, announced some time ago, will remain the same for other types of accommodation; i.e. $1,000 for active treatment beds and $2,000 per bed for the construction of accommodation for the chronically ill and for convalescents.

Dr. J. H. Grove to Head Blindness Control Division

Dr. J. H. Grove of Ottawa has been appointed chief of the blindness control division of the Department of National Health and Welfare, succeeding Dr. F. S. Burke who retired this year. This division works closely with provincial pensions authorities in administering pensions for the civilian blind and co-operates closely with the Canadian National Institute for the Blind.

During World War II, Dr. Grove served with the R.C.A.M.C. in Canada and overseas and until he joined the Department of National Health and Welfare last year he was a medical adviser with the D.V.A. Pension Commission. He is a graduate of the University of Toronto and a specialist in ophthalmology.

Montreal Offers 6-Month Nurses Aide Course

A six-months' course for nurses aides, approved by the Association of Nurses of the Province of Quebec and the Montreal Hospital Council, has been launched under the auspices of six large Montreal hospitals. Candidates must be at least 18 years of age, with a minimum education of one year of high school, and older women will also be encouraged to enrol.

Designed to strike a balance between the advanced duties of a registered nurse and the mere routine of the ward, the course consists of classes given in personal hygiene, ethics, dietetics in relation to the patient's needs, housekeeping, sanitation, and practical knowledge in the care of those with non-acute or chronic illnesses, as well as the care of patients in the convalescent period. Six months of theory with supervised practice, in which the student is provided with uniform, laundry, and room and board at the hospital, will be followed by six months of supervised experience as a paid employee of one of the six hospitals. At the end of a successful probationary year a certificate will be awarded.

Hearing Aids Free in Britain

Hearing aids will now be supplied free in Great Britain to persons who are deaf. An initial order for 400,000 has been placed and it is estimated that another 100,000 may be needed for replacements. The cost is estimated at £4,000,000 per annum.

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Infant and Maternal Death Rates Decrease

For the fourth year in succession, infant and maternal death rates in Canada decreased in 1947. According to preliminary figures compiled by the Dominion Bureau of Statistics, in 1947 as compared with 1946 the death rate for children under one year fell 47 to 45 per 1,000 live births, and the rate for children under one month from 27 to 26. The maternal death rate dropped fractionally from 1.8 to 1.5 per 1,000 live births.

If the final figures confirm the trend shown by the preliminary compilation, the past four years will record a drop of a full 10 points in the infant death rate, from 55 per 1,000 live births in 1944 to 45 in 1947.

The actual number of deaths of infants under one year was 1,592 greater in 1947 than in 1946, but, balanced against an increase from 330,732 to 358,709 in the number of live births, the mortality rate was nonetheless lower than in 1946.

Dr. Couture, director of the child and maternal health division, Department of National Health and Welfare, pointed out that more than half the infant deaths occur during the first month of life. Many of these children could be saved if the mothers received close supervision during pregnancy and gave proper attention to nutrition.

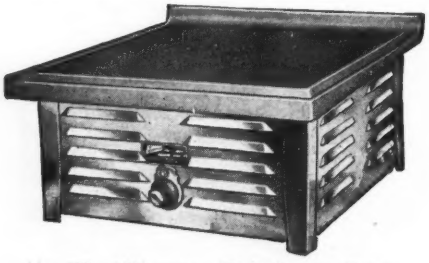
In general, mankind, since the improvement of cookery, eats twice as much as nature requires.—*Benjamin Franklin.*

Coming Conventions

September 6-18—A.C.H.A. Institute for Hospital Administrators, Chicago.
September 18-19—American College of Hospital Administrators, Traymore Hotel, Atlantic City.
September 20-23—American Hospital Association, Convention Hall, Atlantic City.
Week of Oct. 4th—Western Institute for Hospital Administrators, Hotel Vancouver, Vancouver.
Oct. 4-8—Institute on Hospital Personnel Relations, Hotel New Yorker, New York.
Oct. 14-15—Saskatchewan Hospital Association, Saskatchewan Hotel, Regina.
Oct. 18-19—Manitoba Hospital Association, Royal Alexandra Hotel, Winnipeg.
Oct. 18-22—A.C.S. Clinical Congress, Biltmore Hotel, Los Angeles.
November 1-2—Canadian Association of Medical Record Librarians, Royal York Hotel, Toronto.
November 1-3—Ontario Hospital Association, Royal York Hotel, Toronto.
November 1-5—A.H.A. Institute on Hospital Purchasing, Somerset Hotel, Boston.
November 3-4—Ontario Conference C.H.A., St. Michael's Hospital, Toronto.
November 8-10—Associated Hospitals of Alberta, Palliser Hotel, Calgary.
November 15-19—A.H.A. Institute on Advanced Accounting, Municipal Auditorium, Long Beach, Cal.

ELECTRIC GRIDDLE

Automatic Heat Control—150° to 550° F.
For Continuous Duty Commercial Purposes.



No. 153—4000 watts—220/230 volts—2 wire.

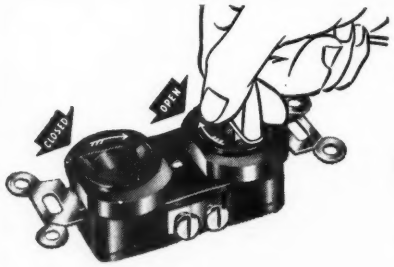
Machined heavy grey iron cooking surface 18" x 18" with grease gutters and hole for connection to waste pipe. Finish—

Grease gutters & edges of casting: hi-heat alumina.
Body: genuine chromeplate over nickel.
Shipping weight — 110 lbs.
Now exempt from Excise Tax.
Now Shipping Promptly.

A wonderful device for many cooking purposes. Guaranteed and approved.

SUPERIOR ELECTRICS LIMITED
PEMBROKE ONTARIO
Manufacturers and Exporters

"NO-SHOK" DUPLEX RECEPTACLES



NO SHORT CIRCUITS
•
NO SHOCKS
•
NO BURNS

Face always closed.

When plug is removed the face is closed tight with a snap-back spring action which prevents foreign particles from entering receptacle.

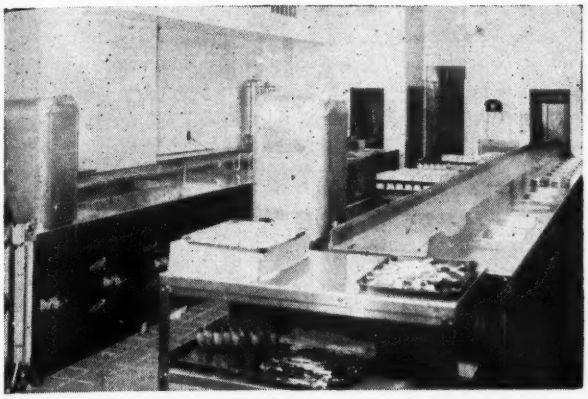
Lifetime spring action . . . firmer plug grasp . . . positive contact always.

NO-SHOK duplex receptacles are ideal for farms and industries, especially where dust, dirt and water are major hazards. Recommended for use in factories, flour mills, grain elevators, barns, etc. Closed cap keeps terminals dry and dust free.

It's a safeguard for children while playing at home and it may be the means of saving a life due to protection from shock.

DISTRIBUTED THROUGH LEADING WHOLESALERS

Verd-A-Ray Electric Products
LIMITED
MONTREAL



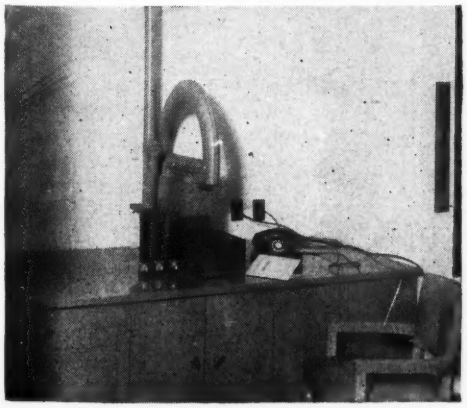
Above: Two make-up belts in the main kitchen of the Victoria General Hospital, Halifax, which conveys trays automatically into two model "A" Trayveyors in an orderly fashion to serve eleven floors. Each Trayveyor is of the double duty type which allows dirty dishes to be returned at the same time to the dish-washing room located behind the Trayveyors.

LAMSON

Trayveyors and Pneumatic Dispatch Tubes

installed in the new

VICTORIA GENERAL HOSPITAL, HALIFAX



Write for illustrated folder describing Lamson equipment designed especially for hospitals.

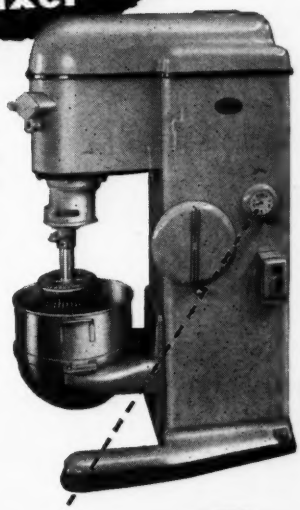
This modern hospital is equipped with twenty-three stations of 2¼" pneumatic tubes for quick dispatch of reports and messages between any two stations by way of a central tube desk. Above photo shows a typical nurses' station.

LAMSON-MUNRO, LIMITED

122 Dundas St. W., Toronto 2

Smoother Mixing

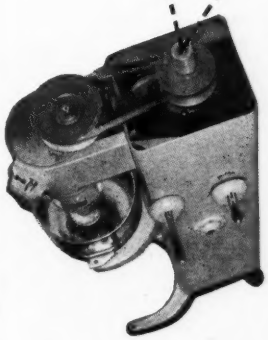
. . . No Shifting Gears with a BLAKESLEE Vertical Mixer



The interesting design above was made by attaching a pencil to a brush beater of a Blakeslee Vertical Mixer. It illustrates how thoroughly all parts of the bowl are covered, assuring smoother, more even mixing.

Any Speed at the turn of a Dial!

All models available in either Duco Finish or Gleaming Stainless-Clad Construction.



The unique speed-changing mechanism shown at left enables you to get *any* (not just 3 or 4) desired speed between high and low without shifting gears or stopping the motor . . . Assures a perfect speed for the mixing of all ingredients . . . a just right speed for every recipe. The strain on a mixer comes from starting and stopping the beater in heavy batches to change mixing speeds. This is eliminated in a Blakeslee Mixer, adding many years of extra service to these streamlined beauties.

Since 1880 BLAKESLEE BUILT KITCHEN MACHINES

BLAKESLEE

DISHWASHERS • PEELERS • MIXERS

G. S. BLAKESLEE & CO., LIMITED
1379 BLOOR ST. WEST, TORONTO 9, ONTARIO

Fire Precautions

(Concluded from page 38)

effect in preventing the rapid spread of fire throughout the building.

Special items to which I would like to draw your attention include electrical circuits and appliances which must be well maintained with only vapour-proof appliances, outlets, switches, light globes, et cetera, being allowed in operating, anaesthetic, and other rooms where explosive gasses may be used. All equipment in these locations should be grounded to eliminate the possibility of sparks from the electric circuits or accumulations of static electricity.

An item which must not be overlooked is the bulk storage of drugs and sundries. Nearly all larger hospitals stock considerable quantities of these commodities, many of which are, in themselves, of a non-flammable nature but which in contact with another, may be not only flammable but explosive.

All bulk storage of drugs demands the utmost in good housekeeping methods, and should be maintained in a thoroughly dry, fire resistive room, the keys of which should be at all times in the possession of thoroughly reliable persons only. Broken packages should be kept in air tight containers and leaky fluid containers must not be permitted. Due to the intense heat developed by fire in alcohol, ether and similar fluids, it is advisable to maintain a quantity of fine, dry sand, in the vicinity of this storage to care for any running fire developed from a spill of these fluids.

Now for a final word to personnel of the many small out-post hospitals staffed by a limited number of nurses and orderlies who are urged to be especially conscious of their fire hazards. Many of these institutions are housed in the large older residences of the community, to which additions have been made, and with very limited protection from organized fire brigades. If your electric fuses are burning out at an abnormal rate on ordinary circuits which should be fused at not more than 15 amps. take immediate action to have the circuits examined by a qualified electrician. Fuses of over 15 amps. should not be used unless heavier than ordinary wires have been installed. Any failure in heating or cooking equipment should receive immediate attention, and do not allow any of this equipment, including pipes, to be nearer than nine inches to walls or ceilings without insulation. Stoves or ranges without legs at least four inches in height, unless sitting on a foundation built from grade, should be provided with four-inch tile as insulation for the floor beneath.

Your attending doctors and surgeons do not make hit and miss decisions for the treatment of their patients. Our Department recognizes the wonderful work you are doing to relieve suffering among the human race, but I must request that you each and all ask yourselves the question, "Am I doing everything I can to prevent loss of life by fire?"

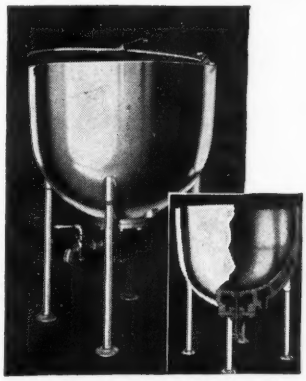
Executive

"What is executive ability, Father?" asked the serious lad.

"Executive ability, my boy, is the art of getting the credit for all the hard work that somebody else does."

For Swifter, Cleaner Kitchen Service . . . use

SULLY CAST ALUMINUM

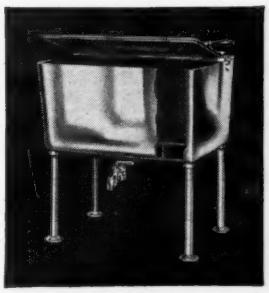


Steam Jacketted Kettles; cast cover securely fastened to kettle. Designed for 40 pounds or less steam pressure.

Here are 8 reasons why Sully cast aluminum will increase efficiency and insure sanitation in YOUR kitchen.

1. SAVE UP TO ONE-THIRD ON FUEL.
2. No seams, rivets or corners, therefore, ease of cleansing.
3. Liberal thickness and texture means even distribution of heat.
4. Heavy cast tight fitting lids control cooking odors.
5. All flavor laden vapors retained.
6. Less food shrinkage.
7. Completely sanitary.
8. Practically indestructible.

Deep Stock Pots; with or without spigot. Your choice of cast aluminum or steel spun covers.



Steam Roasters; one piece construction for quick heating, easy cleaning. Unusually small amount of shrinkage in meats.

Sully

For further details phone LY. 5495 or write us

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"MOIST HEAT"

FOR

Pain, Swelling, Soreness

In the treatment of boils or other localized infections where "Moist Heat" is indicated, the "Moist Heat" of ANTIPHLOGISTINE helps relieve pain, swelling, and soreness.

Applied comfortably hot, ANTIPHLOGISTINE supplies "Moist Heat" for several hours. ANTIPHLOGISTINE may be used with chemotherapy.

The "Moist Heat" of ANTIPHLOGISTINE is also effective in relieving the pain and swelling of a sprain, bruise or similar injury or condition.

Antiphlogistine

(Made in Canada)

The Denver Chemical Mfg. Company
286 St. Paul Street West, Montreal

Provincial Notes

(Continued from page 70)

TORONTO. A civic grant of $350,000 has been requested by the Toronto Western Hospital to aid in an expansion building program estimated at $1,750,000. One unit planned will house some 175 beds and 100 bassinettes for a new maternity and gynaecological section. In addition it is proposed to erect a nurses' residence to accommodate 125 staff members, with training school facilities, lounge, and study rooms. Included in the plans are a new emergency operating room, and fracture room, as well as a service building. It is hoped that approximately $684,000 will be raised by public subscription.

* * * *

SIOUX LOOKOUT. Construction has commenced on a new Indian hospital to be used as a combined general hospital and sanatorium, with accommodation for 60 patients. An isolation wing will be one of its features. The hospital will employ a doctor and each of the newly-planned district outpost divisions will have trained nurses in charge.

* * * *

WINDSOR. A sod-turning ceremony marked the beginning of work on the new student nurses' residence at the Metropolitan General Hospital. The three-storey brick building, connected to the main hospital by a tunnel, will house 100 nurses and, as a training centre, will provide classrooms, laboratories and a demonstration room. City, provincial and federal authorities have co-operated in making this project possible.

Quebec

LAC-AU-SAUMON. Les Soeurs Servantes de Notre-Dame du Clerge are planning to construct a hospital for incurables. It is estimated that the hospital will cost in the neighbourhood of one half million dollars.

* * * *

MONTREAL. The City of Montreal is looking forward to the completion next year of a $3,000,000 tuberculosis sanatorium. Back of the 560-foot structure are separate buildings for a sisters' and a nurses' home, a

(Concluded on page 110)

SUPPLIES FOR ALL CRAFTS

Carving, clay modelling, plastics, leathercraft, silkscreen, weaving, metalcraft — and dozens more. Each can develop a worthwhile skill in your pupil. We can supply good, easy-to-follow instruction books on all crafts. Our staff of expert hobby crafters will be pleased to advise on hobby questions. Special instruction classes are available for those who desire them. Write for our price list of craft supplies.

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MONTREAL - TORONTO

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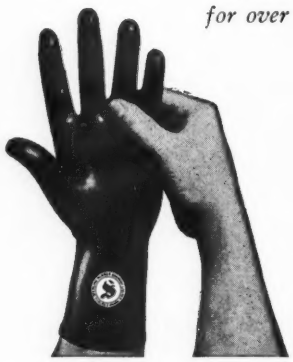
STERLING GLOVES *featuring*

Medium Weight in a Uniform Thickness

Specialists in Surgeons' Gloves for over 35 years.



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Vibrationless Storage

CLAD IN STAINLESS STEEL

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- Liquid Plasma
- Biologicals

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- Hospitals all over the Dominion look to VENDALL for the last word in Blood Bank Equipment.
- Only progressive Hospitals with VENDALL Blood Banks are providing complete service.
- Surgeons will have "plus" confidence when a VENDALL Blood Bank is in the Hospital.
- Profitable Blood Banks are "VENDALL" Blood Banks; proven by actual use in Hospitals.
- Institutions using VENDALL Blood Banks will testify they pay handsome dividends.
- Throughout Canada, Medical Technicians have contributed to the development of VENDALL during and since the war.
- Ask the Hospitals who have VENDALL Blood Banks in operation.
- Leading Hospitals look to the Leader—VENDALL—the Blood Bank Specialists.
- S.S. 80 "VENDALL" Model number for the Roto Blood Bank Jr., meets the approval of the CANADIAN RED CROSS BLOOD TRANSFUSION SERVICE.

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Quality you trust
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TRADE MARK

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COCA-COLA LTD.

recreational and health centre, and a boiler room. Built by the Provincial government, the sanatorium will be operated by the Soeurs de la Misericorde.

* * * *

SHERBROOKE. The appointment has been announced of Miss Vera L. Graham of Port Arthur, Ontario, as superintendent of nurses at the Sherbrooke Hospital. Miss Graham, former superintendent of nurses at the Homoeopathic hospital in Montreal and more recently on the staff of the Winnipeg General Hospital, will succeed Miss Olive G. Harvey who is retiring.

* * * *

THREE RIVERS. Citizens of Three Rivers may soon take advantage of the services of the new Sainte-Marie Maternity Hospital. The four-storey building, rapidly nearing completion, will have a capacity of 110 beds and 110 bassinettes. It is to be operated by Les Reverendes Soeurs de Misericorde.

Standing Rules and Orders

In the middle of the seventeenth century, it was decreed that half of the rooms and convenient places in all hospitals in England employed for care of wounded and sick people should be reserved during the time of war at sea, and disposed to such as shall be wounded in the service of the Navy.

The rules for Naval Patients included:

". . . that they take not tobacco in their beds to the endangering of the house by fire."

The year 1700 has an entry:

"The Sisters to see that no card playing nor dicing takes place in the house."

ADMINISTRATOR AVAILABLE

Experienced administrator available as superintendent, as assistant or as business manager. Male, 34, married, Protestant, ex-R.C.A.F. medical branch (lay). Nine years experience as assistant to superintendent of civilian general hospitals. Would go anywhere in Canada. Available at once. Box 181E, The Canadian Hospital, 57 Bloor St. W., Toronto 5.

Vacancies for General Duty Nurses

at the University Psychiatric Centre. Applicants must be of good standing. Stimulating experience with good prospects. All staff live out—forty-eight hour week.

Salary scale—if registered in Ontario $1,840-$2,040.
if not registered in Ontario $1,640-$1,840.

Apply Director of Nurses, Toronto Psychiatric Hospital, Surrey Place, Toronto.

Vacancies for Head Nurses

(in charge of wards day and night) at the University Psychiatric Centre. Applicants must be of good standing. Stimulating experience with good prospects. All staff live out—forty-eight hour week.

Salary scale—$2,040-$2,240.

Apply Director of Nurses, Toronto Psychiatric Hospital, Surrey Place, Toronto.

Vacancies for Nurse Instructors

at the University Psychiatric Centre. Applicants must be experienced in teaching and psychiatric nursing. The positions provide an outstanding opportunity for fostering nursing in all its aspects.

Salary scale—$2,240-$2,340.

Apply Director of Nurses, Toronto Psychiatric Hospital, Surrey place, Toronto.

Hospital and Institutional

CROCKERY, SILVER and GLASSWARE

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STEAM-CLOX record sterilization in unmistakable color changes.

EXACT STERILIZATION

Always

STEAM-CLOX are the *only* controls that determine definitely, Time, Steam, Temperature, indicating the success or failure of your sterilizing technique. You know, positively, if every pack is absolutely sterile. STEAM-CLOX are automatic, certain. Absolutely will not react to dry heat.

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FREE DEMONSTRATION SUPPLY

STEAM-CLOX make your hospital error-proof in this vital department, and at a cost of only 2½c per pack. Write today for ample free supply for proving in your own autoclave. See for yourself why so many hospitals use STEAM-CLOX.

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CANADIAN AGENTS – TORONTO, MONTREAL

Easy ON THE FEET....

COMFORTABLE, LONG LASTING

Tile - Tex

IF floors had the gift of speech—what a story hospital wards and corridors could tell!

But TILE - TEX floors do their talking even without words. You can read the TILE - TEX story any day in the cheerful faces and easy bearing of many hard-worked hospital staffs.

Nurses come off ward duty . . . with a spring still in their steps! In the pre - Tile - Tex days, when **comfortable** floors were still unheard of, a session of walking the hard unyielding floors of the wards was enough to exhaust any healthy person.

And watch the cleaning people at their chores. Sure it's work to clean a floor—any floor—but what a difference between cleaning smooth TILE-TEX and those awful back-breaking scrub jobs. Tests show how much cleaner TILE-TEX is too. Thanks to TILE-TEX smooth surface, dirt stays **on top** where it's easier to get at. And since there's no way for dirt to grime in, sterilizing TILE-TEX is a simple job.

TILE-TEX is not expensive either; the initial cost is surprisingly low.

Easy to install, and highly fire-resistant, TILE-TEX comes in a wide variety of lovely colours that keep their healthy freshness for the extra long TILE-TEX lifetime.

Write today for information.

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"The best in flooring"

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In a hospital, a nurse stands for speed and efficiency. She must literally be everywhere at once. This has become reality with ELECTRO-VOX Hospital Communication—it does the work of two! With ELECTRO-VOX at her elbow to pick up the slightest sound and to relay instructions, the nurse is in direct contact with her many patients and members of the staff. Efficiency and speed are doubled at the flick of a switch.

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NURSE vs. PATIENT
DIET KITCHEN vs. MAIN KITCHEN
LABORATORY vs. PHARMACY
PAGING OF DOCTORS AND STAFF
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